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	345431	A. BUILDING _____ B. WING _____	12/19/2014

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OUR COMMUNITY HOSPITAL	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to ensure resident's clothing fit and failed to obtain permission prior to entering a resident's room for 2 of 4 residents (Residents #47 and #7) reviewed for dignity. The findings included: 1. Resident #47 was admitted to the facility on 6/17/14. Diagnoses included dementia, psychotic disorder, hypertension and diabetes. The most recent Minimum Data Set (MDS), a quarterly dated 9/26/14, revealed Resident 47 usually understood others and was usually understood by others, had severe cognitive impairment, did not reject care, was independent with walking in room and dressing, required supervision for walking in the corridors, was occasionally incontinent of urine and always continent of stool. Review of the most recent Care Plan revealed no documented problem or need regarding dressing or clothing. Review of Resident #47's weight history revealed he gradually gained 19 pounds from 6/17/14 - 12/11/14. On 12/18/14 at 12:03 PM, Nursing Assistant (NA) #8 and NA #9 were observed to enter Resident #47's room to assist him to the dining room. He was sitting in his chair with his pants open. He	F 241	Corrective action Resident #47: A.Closets were inventoried by the Director of Nursing and the Assistant Director of Nursing. Clothes that no longer fit were bagged, labeled and removed from his closet. 12/19/14 The responsibile party for resident was notified by the facility social worker. (12/19/14) The facility purchased six (6) pairs of sweatpants for resident #47 in his size for proper fit. (1/16/15) To ensure that other residents were not affected or at risk for having improperly fitting clothing, the closets of all the residents in the facility have been inventoried and clothing that no longer fits or in need of repair was bagged, labeled, and removed from the closets. This was accomplished by the facility social worker, the hhousekeeping staff, and Personal Care Attendant(PCA) (12/19/2014 through 1/16/2015) B.Facility Social Worker mailed a letter to the Responsible Party (RP) of each resident in the facility enlisting their help in removing all worn out clothing, clothes that no longer fit or were in need or repair.	1/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/18/2015

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F 241	Continued From page 1 was assisted to stand and fasten and zip his pants but they were too small to close. NA#8 took another pair of pants out of his closet and encouraged him to change. The resident refused and proceeded to walk out of his room to the dining room, using one hand to pull his pant back up when they got to hip level. NA #8 was interviewed on 12/18/14 at 12:15 PM. She stated the morning routine for Resident #47 was for staff to lay out his clothes for the day and set him up for a bath. He bathed and dressed himself. NA #8 indicated the resident frequently left his pants unfastened and he held and pulled them up when he walked. She stated this had been a problem for a while. NA #8 indicated she did not report any too small clothing to anyone. She added that rather than upset the resident about changing she let him dress the way he wished and walk to the dining room. During an interview on 12/18/14 at 12:31 PM, the MDS nurse, who was supervising in the dining room, stated Resident #47 walked around with his pants low, holding them. The MDS nurse said the facility had bought the resident a belt but he continued to wear his pants low. Nurse #2 was interviewed on 12/18/14 at 2:06 PM. She indicated staff tried to make sure his clothes fit right and to keep a belt on him. Nurse #2 stated when seen with pants that do not fit, staff try to persuade Resident #47 to change. The nurse indicated his clothes were kept in his closet whether they fit or not. During an interview on 12/18/14 at 3:24 PM, the Assistant Director of Nursing (ADON) stated Resident #47 had clothes that were too big and too small. When he wears clothes that do not fit properly he will not change and we let him have his way.	F 241	(1/15/2015) C. Measures which have been put into place: 1. Closets will be checked on a quarterly basis for improperly fitting clothing and removed. 2. The Social Worker will mail letters to the responsible party of each resident on an annual basis, or more often if during inventory of the closets articles of clothing are found to be in need of repair or no long fit, the social worker will mail a letter or notify the responsible party by telephone of the need to help in getting old clothing out of the closet. D. To monitor for compliance of properly fitting clothing for resident #47 and for all residents with the potential to be affected, room audits will be done through daily ambassador rounds. A minimum of ten (10) residents will be checked by assigned ambassador. (Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Social Worker and Activity Director) The Staff Development Coordinator will be responsible for compiling the information from ambassador checklists and presenting a detailed report to the Quality Assurance Committee monthly for three months and then quarterly thereafter. Quality Assurance report will include any corrective actions taken for any problems encountered. Resident #7 A. The issue of knocking on the door before entering the room has been addressed through in-service education to	

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F 241	Continued From page 2 2. The resident was admitted on 12/20/13 with diagnoses that included orthostatic hypotension, peripheral vascular disease, stroke and depression. The most recent Minimum Data Set (MDS), an annual assessment dated 11/25/14, coded the resident as cognitively intact. There were no moods, behaviors or rejection of care identified. During an interview with the resident on 12/16/14 at 10:19 AM, Nursing Assistant (NA) # 3 knocked on the resident ' s door. Without waiting for an invitation to enter the room, the NA walked into the room. Carrying linen in her arms, she walked to the unoccupied side of the room. NA # 3 did not acknowledge Resident # 7 had visitors and was in the middle of a conversation. The NA did not leave the room until asked. When NA # 3 exited the room, Resident # 7 stated entering the room without invitation happened all the time and it was to be expected when you lived in a nursing home. He stated he knew it was a dignity issue. He added to him it was like someone walking into your house without being asked to come in. An interview was held with NA # 3 at 3:00 PM. She was taught to knock on the resident ' s door, wait for a response and then open the door. The NA stated she remembered yesterday entering Resident # 7's room. She stated after she knocked, she thought Resident # 7 told her to come on in. The Assistant Director of Nursing (ADON) was interviewed on 12/17/14 at 5:28 PM. The ADON stated staff had been taught to knock on a	F 241	all facility staff, including nursing,housekeeping, laundry,dietary,therapy, and business office staff. (Completed by Social Worker January 6, 2015 through January 14, 2015) Handouts were given to all staff in attendance at the in-service entitled "Patient's Rights" and "Patient's Rights and Dignity". The focus of the in-service was about the resident's right to privacy and the staff's responsibility to knock before entering a resident's room. The Director of Nursing held a mandatory staff meeting for all for all nursing staff, licensed and unlicensed with the focus on privacy, dignity and knocking on doors before entering a resident's room. (1/12/15) B. For resident #7 and for all residents having the potential to be affected by the same practice of not knocking on a resident's door a policy has been written, in-serviced, and initiated (1/12/15) Reviewed with staff during in-service. Nursing staff have been instructed to knock, wait, knock again, if no answer announce who you are, open the door to see if the resident is alright. Ask resident(s) if it is alright for you to enter. All staff have been instructed at the staff meeting that if a resident has visitors to return later, unless resident invites you in. C. To ensure that the practice of not knocking on doors does not occur again, the Assistant Director of Nursing, Minimum Data Set Coordinator, Activity	

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F 241	Continued From page 3 resident's door and request entry. If the resident does not respond, staff had been instructed to open the door slightly to ensure the resident is ok. If the resident is engaged in a conversation, the expectation would be for the staff person to close the door and return at a later time. An interview was held with the Director of Nursing (DON) on 12/18/14 at 9:36 AM. She stated staff had been taught to knock on the resident's door and wait for a response. If there was no response, staff had been taught to knock again. The DON stated staff should announce themselves and ask permission to enter. If there is still no response, the DON stated she expected staff to slightly open the door and make sure the resident was ok. In essence, the DON stated, an invitation to enter the room was expected. She added she had told staff this was the residents' home and there was a need for respect	F 241	Director,Social Worker and Staff Development Coordinator have been monitoring by observation whether staff members are knocking on the resident(s) door prior to entering room. Ambassador Rounds are done daily by an assigned ambassador. There are a minimum of 10 observations done per day. D. The Staff Development Coordinator (SDC) will be responsible for compiling information from each ambassador's checklist and presenting a detailed report including any problems encountered during rounds, any trends, and corrective action(s). The SDC will present this report to Quality Assurance Committee each month for 3 months and quarterly thereafter. (SDC)	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and a family member and review of medical records, the facility failed to encourage and/or provide out of room activities for 1 of 2 residents (Resident # 38) that was reviewed for activities.	F 248	A. For resident #38 the requirement has been met as evidenced by the resident's attendance in out of room activities at least once per week. The Activity Director is responsible for ensuring that resident #38 is taken to out of room actvities	1/16/15

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F 248	Continued From page 4 Findings included: Resident # 38 was readmitted on 8/20/14 with diagnoses that included stroke, hypertension and chronic pain. Review of the December 2013 initial Activity Assessment indicated Resident # 38's activity interests included spiritual-religious activities, watching television and music. Preferred level of participation in activities included passive, one on one and small groups. Review of a 9/2/14 Activity Progress Note indicated the resident received frequent visits from family. The note also indicated the resident received in room bingo, and one to one in room visits with music. The 9/5/14 Quarterly Minimum Data Set (MDS) indicated the resident had no speech and was rarely/never understood and rarely/never able to understand. She was assessed with short and long term memory impairment and severely impaired cognitive skills for daily decision making. A 12/03/14 Activity progress note indicated the resident was unable to participate in activities related to health disabilities however received one to one in room stimulation that included music, television and in room bingo. On 12/15/14 at 11:15 AM, the family member was interviewed. She stated staff did not take Resident # 28 to any out of room activities. She stated she wished they did; adding the only time the resident got out of her room was when she took her.	F 248	(1/16/15) B. For other residents having the potential to be affected by little or no attendance to out of room activities, the activity director is responsible for identifying those residents by the process of talking with family members or responsible party, obtaining information during the activity admission assessment which addresses the resident's level of participation, level of activity and any cognitive or physical limitations. The information obtained will be addressed in the resident's care plan. Activity Assessment will be done on admission and quarterly by the Activity Director. C. The Activity Director will monitor in room activities for resident #38 and for all residents by the use of the "Individual Resident Daily Activity Record". The goal for each resident is to attend 50% of daily activities quarterly. Care plan will be reflective of each resident's individual activity level, their participation in activities , or their refusual to attend activities. (1/16/15) D. The Director of Nursing or the Minimum Data Set Coordinator will monitor compliance for goal of 50% attendance to daily activities quarterly. This will be accomplished by review of Individual Resident Daily Activity Record or by review of Activity Assessment. The findings of the Individual record review and review of the activity assessment will be presented to the Quality Assurance	

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F 248	Continued From page 5 Review of the Activity Calendar posted in hall indicated on 12/15/14 at 11:00 AM, Bible study had been available. Observation indicated Resident # 38 was in the geri chair in her room, but did not attend the religious activity. On 12/17/14 at 11:00, a school music program was offered and at 11:30 AM, the activity calendar indicated music therapy was offered. The resident was observed in her geri-chair in her room, but was not taken to either of the musical activities. An interview was held with Nursing Assistant (NA) on 12/17/14 at 2:16 PM. She stated Resident # 38 was not taken out of her room unless her family member took her out. The NA stated she did see the Activity Director (AD) in the room marking the resident's bingo sheet. She offered no reason why the resident did not go out of the room. Nurse # 1 was interviewed on 12/17/14 at 4:16 PM. Nurse # 1 stated Resident # 38 was out of bed and in a geriatric chair (geri chair) on Monday, Wednesday and Fridays. The nurse added the resident did not go out of the room unless the RP took her out. She stated she did see activity staff in the room, but was unaware of what they were doing with the resident. On 12/17/14 at 4:55 PM, NA # 2 was interviewed. She stated Resident # 38 was up in her geri-chair when she arrived to work at 3:00 PM. The resident was typically out of bed on Monday, Wednesday and Friday. The NA added she had not seen the resident out of her room. NA # 2 stated she was not aware of the resident going to any activities.	F 248	Committee (QAC) for a period of 3 months and quarterly thereafter. Problems encountered, such as less than 50% attendance to daily activities will be addressed with the Activity Director with recommendations by Quality Assurance Committe members for improvement. (1/16/15)	

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F 248	Continued From page 6 An interview was held with the AD on 12/18/14 at 3:20 PM. The AD stated Resident # 38 was unable to participate in activities, but was able to set in on spiritual and musical activities. She added Resident # 38 was out of bed 2 to 3 times per week. The AD stated it would benefit the resident to attend group activities at least 1-2 times per week; adding typically, she attended at least one out of room activity per month. The AD stated she kept participation logs that would show what activities Resident # 38 had attended. Review of the activity log for September 2014 indicated Resident # 38 had attended no out of room activities. In October 2014, Resident # 38 attended no out of room activities. Review of the November log indicated Resident # 38 received 2 in room activities and no out of room activities and in December, the activity log documented no out of room activities for Resident # 38. Nurse # 2 was interviewed on 12/18/14 at 3:43 PM. She stated she had worked since August and had not seen the resident out of her room except when the RP took her out of her room. Nurse # 2 added she had not seen anyone from activities in the room providing activities. The nurse did say the television stayed on most all the time, adding the resident really did not pay attention to the television. The Activity Director was interviewed and reviewed the calendar on 12/18/14 at 4:05 PM and stated Resident # 38 had not attended the activities offered on Monday or Wednesday of the week. The AD could offer no reason why the resident had not attended. Observation of the posted Activity Calendar for	F 248		

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F 248	Continued From page 7 12/19/14 at 10:30 AM indicated at 10:30 AM church was offered, at 11:00 AM morning stimulation was offered and at 11:30 music therapy was offered. Observation during the times the activities were offered revealed the resident was out of bed, in her geri-chair, in her room, and had not been taken to the musical and/or spiritual activities. On 12/19/14 at 2:23 PM an observation was made of Resident # 38 sitting in her geri-chair. A musical activity was taking place in the dining room. The resident remained in her room. An interview was held with NA # 3 who was in the resident's room. She stated there was no reason the resident could not go to the activity if the nurse would come unhook her tube feeding. Nurse # 2, was interviewed immediately after the NA. She stated no one had told her the resident was up or the tube feeding needed to be discontinued so Resident # 38 could attend the activity.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		1/16/15

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F 278	Continued From page 8 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 20 residents (Residents #15, #30 and #43). The findings included: 1. Resident # 43 was admitted on 5/23/14 with diagnoses that included chronic kidney disease requiring hemodialysis, diabetes and chronic pain. On 7/10/14, a physician's progress notes indicated Resident # 43 received dialysis. The Quarterly Minimum Data Set (MDS), dated 9/5/14, did not capture the resident's dialysis under the section Special Treatments. The MDS Coordinator was interviewed on 12/19/14 at 9:47 AM. He stated he had been the MDS Coordinator for 6 months and had not received any formal training on completion of the MDS. The MDS nurse added that not coding	F 278	A. For residents #43, #15, and #20 the MDS has been corrected to reflect each resident's current status. 1)For resident #43 the MDS had been corrected to include dialysis under Section O-Special Treatments. Corrected MDS was submitted. A care plan was updated to reflect hemodialysis and care of fistula site. (MDSC 12/6/14) 2)For resident #15 the MDS was corrected to include the use of eye glasses in Section B. Corrected MDS was submitted. (MDSC 1/18/15) 3)For resident # 30 the MDS had been corrected to include the use of a diuretic in Section O. The corrected MDS was submitted. (MDSC 12/12/14) B.Corrective action will be accomplished for those residents who have the potential to be affected by incorrect coding on the	

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F 278	Continued From page 9 dialysis was an oversight. 2. Resident # 15 had been admitted on 1/31/07 with diagnoses that included depression, hypertension and arthritis. On 4/29/14, Resident # 15's vision was evaluated. The consultation report indicated the resident's visual acuity was 20/40 in both the right and left eye. A quarterly Minimum Data Set (MDS) with a date of 10/10/14 indicated the resident was cognitively intact. The MDS identified Resident # 17 with impaired vision and indicated there were no corrective lenses used. An interview was held with Nursing Assistant # 1 on 12/17/14 at 2:30 PM. The NA stated Resident # 15 wore glasses to read only. The NA added Resident # 15 had no complaints about vision or eye problems. An interview was held with the MDS Coordinator on 12/19/14 at 9:37 AM. He acknowledged Resident # 15 was coded as having difficulty with vision and wore no glasses. He acknowledged he knew Resident # 15 wore glasses when reading. The MDS nurse stated he coded the MDS to reflect no glasses since he thought the question on the MDS meant did the resident wear glasses during the assessment and had nothing to do with if she owned glasses or normally wore glasses. He stated he knew Resident # 15 usually wore glasses for reading, but stated he did not ask her to put her glasses on prior to the visual assessment for the MDS.	F 278	MDS, by weekly MDS audits/reviews. The Director of Nursing will meet with the MDSC each week to go over and review the MDSs which have been completed; using the resident's medical record, physician orders and electronic medication administration record for reference and comparison. (DON 1/16/15) C.To ensure this requirement is met not only for residents #15, 30 and 43, but for all residents as well the following process is in place. 1) The MDSC will review the resident's records including new physician orders for new medication orders or treatments, monthly summary, daily check of the 24hr shift report at nurse's station for any changes which occurred on each shift for the previous day,and any physician or nurse's notes that reflect changes in condition, status or function The information and findings will be used to identify any changes since last MDS was done to ensure that MDS is correctly coded. (MDSC) 2)The MDSC will coordinate with the members of the Interdisciplinary team (IDT) to further ensure that their sections of the MDS are accurate and complete. This will be accomplished by a hard copy of the MDS being printed and reviewed by the IDT. Any corrections needed will be corrected on the hard copy of the MDS and then entered into the electronic MDS by the MDSC. 1/16/15 MDSC) D. The Director of Nursing will monitor for	

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F 278	Continued From page 10 3. Resident #30 was readmitted to the facility on 9/4/14. Diagnoses included hyptertension, congestive heart failure and dehydration. Review of physician orders dated 9/4/14 included bumetanide (a diuretic) 1 milligram (mg) by mouth (po) daily. Review of a significant change MDS dated 9/11/14 revealed the resident was not checked as receiving a diuretic. The Care Plan dated 9/12/14 revealed a problem of a risk for dehydration related to resident's history of refusing fluids at times. During an interview on 12/18/14 at 3:07 PM, the MDS nurse indicated the MDS should have been coded as Resident #30 receiving a diuretic 7 days during the look-back period. The MDS nurse stated it was a coding error.	F 278	compliance through the use of a check off sheet, which includes the resident's name, the date the MDS was reviewed and by whom,the date care plan was initiated and by whom,problems identified/corrected. The DON will report quarterly to the QA meeting on the findings of weekly MDS audits with corrective action taken as needed to ensure MDS is accurate and complete. (1/16/15)	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		1/16/15

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F 279	Continued From page 11 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and observation, the facility failed to develop care plans for 2 of 2 residents (Residents #33 and #42) with behaviors, 1 of 1 resident (Resident #43) on dialysis, 1 of 4 residents (Resident #10) reviewed for nutrition, 1 of 3 residents (Resident #15) reviewed for pain and 1 of 5 residents (Resident #19) reviewed for unnecessary medications. The findings included: 1. Resident #33 was readmitted to the facility on 4/3/14. She had diagnoses which included Diabetes, dementia and leg ulcers. The Minimum Data Set (MDS) dated 3/31/14 revealed she was coded as wandering and was severely cognitively impaired. The MDS dated 8/6/14 revealed she was severely cognitively impaired, independent with bed mobility and needed supervision for transfers. The Care Area Assessment (CAA) revealed the resident had dementia. The Care Plan with a review date of 11/20/14 for Resident #33 revealed she was at risk for elopement related to confusion/dementia. The Care Plan did not address wandering. A medical record review revealed a Monthly Nursing Summary dated 3/14/14 which revealed Resident #33 had moderately impaired decision making skills with periods of altered perception and the behavioral symptoms was documented as wanders. The next Monthly Nursing Summary dated 4/26/14 revealed this same information. An Incident report dated 4/13/14 revealed	F 279	A. For residents #33 and #42 care plans have been written and implemented addressing behaviors. Completion date 12/29/14 For resident #43 and all other dialysis residents a care plan has been written and implemented for dialysis and the assessment of graft site daily. The care plan will be reviewed and updated at least quarterly and as needed in order to ensure that the resident's needs are identified and met. (12/29/14) For resident #15 with complaint of pain and refusal of pain medication and for all residents with potential to be affected, a plan of care has been written and implemented pertaining to residents frequent refusal of pain medication. Care plans will be reviewed and updated at least quarterly and as needed in order to ensure that the resident's needs are identified and met. (MDSC,IDT,DON)12/29/14 For resident #19 and all residents with the potential to be affected, the plan of care has been revised to list the target behaviors under the approaches. (12/29/14)	

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F 279	Continued From page 12 Resident #33 propelled herself into another resident's room. The other resident began kicking Resident #33 in both lower extremities. The report revealed that resident #33 was pleasantly confused and thought the other resident was her relative. The report indicated the altercation was stopped by staff members. During an interview with Nurse #3 on 12/17/14 at 6:23 PM she stated Resident #33 wandered into other residents' rooms and mixed up their things. On 12/17/14 at 9:56 AM the Social Worker (SW) stated that Resident #33 wandered but was easily redirected. She stated that the facility staff needed to be vigilant on the location of Resident #33 and that Resident #33 wandered throughout the building. She stated she would expect the care plan to reflect the resident's behavior of wandering in the building. During an interview with the MDS nurse on 12/19/14 at 2:11 PM he reported that Resident #33 gets around the building and that she wanders. He stated the Social Worker completed the section of the MDS on behaviors. He added that she did not have a care plan for wandering because it did not trigger. During an interview with the Director of Nursing (DON) on 12/19/14 at 10:50 AM she stated Resident #33 wandered into another resident's room and the resident in the room kicked Resident #33 in the legs, causing bruises. The DON stated Resident #33 had a care plan for elopement but not for wandering. She added that wandering and elopement were not the same thing and that Resident #33 should have been care planned for her wandering behavior. 2-Resident # 10 was admitted to the facility on 5/6/13 with diagnoses that included hypertension,	F 279	Resident #10 has been added to the weekly weights. A nutritional supplement was started 12/29/14 3X day. The care plan has been updated to show weight monitoring weekly and nutritional supplement was added. CDM will present to the Risk meeting a report on each resident with significant weight changes and with the with recommendations from Certified Dietary Manager (CDM), Registered Dietician and physican. The CDM will follow up with order if supplements have been added or if there are other changes to prevent further weight loss. The CDM will present findings and trends at the QA meeting at least quarterly and more often as needed. The CDM will also present to the IDT findings, trends, follow up, care plan revisions as needed supplements and assessments. To ensure that any other residents with the potential to be affected the CDM will follow the Prevention of Weight Loss Policy. B. Corrective action has been accomplished by participation of the licensed nursing staff,certified nursing assistants,and therapy staff in weekly care conference.Care plans will be reviewed during care conferences with input from nursing staff, physician, pharmacist and therapist. Problems are identified by the team and care plans are initiated with goals and interventions individualized for each resident.(12/29/14) C.Measures which have been put into	

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F 279	Continued From page 13 pain and arthritis. Vital sign record indicated the resident's weight on 9/4/14 was 160 pounds and on 10/8/14 Resident # 10 ' s weight was recorded as 161 pounds. Review of weights recorded for 11/4/14 indicated Resident # 10 weighed 145 pounds which reflected a 16 pound weight loss in one month. A Nutritional Assessment, dated 11/18/14, indicated Resident # 10 had a 9.94% weight loss in one month. The care plan, last reviewed on 11/20/14, identified swallowing problem related to a sore throat/gastroesophageal reflux disease. The diet was listed as pureed. The resident ' s current body weight was listed as 145 pounds with an acceptable body weight of 100 pounds. The goal was she would not choke or aspirate and maintain current weight of 145 pounds. The unintended significant weight loss was not addressed on the care plan. An interview was held on 12/18/14 at 9:50 AM with the Director of Nursing (DON). She stated she expected significant weight loss to be care planned, adding the Dietary Manager (DM) was responsible for nutritional care plans. On 12/18/14 at 10:41 AM, the DM was interviewed. The DM stated typically significant weight loss was care planned. She added a care plan for significant weight loss was not developed for Resident # 10 because she thought it was weight/scale error and not true weight loss. The DM stated there had been no interventions added	F 279	place to ensure that problems are identified through: review of the resident medical record toinclude nurse's notes, physican progress notes, electronic medication administration record checking for discontinuation or addition of new medications, fall assessment score to determine resident's fall risk,antipsychotic flow sheets are reviewed as applicable for behaviors and will be included on the care plan. For newly admitted residents the licensed nursing staff completes the Admission Data Base, which serves as a "history and physical" for them, the information obtained here on the data base will be reviewed by the MDSC and will be used to complete the MDS and to generate/initiate a care plan. The nursing staff will, as they always have, make any changes to the resident's care plan on the hard copy of the care plan. The MDSC is responsible for entering the data into the electronic MDS file. Although this is not anew process, the nursing staff have been re-inserviced on updating care plans as they note changes in status or condition. (MDSC, Assistant Director of Nursing) 12/29/15 D.The DON will present a detailed report at the monthly QA meeting with an analysis of the findings, trends, follow up and care plan revisions monthly for 6 months and quarterly thereafter. Information for the report will be obtained from audits of the care plans and from the MDS Review Checklist. The DON will	

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F 279	Continued From page 14 for weight loss since the resident's intake had not changed and she had not been sick. 3- Resident # 15 was admitted on 1/31/07 with diagnoses that included arthritis, hypertension and involuntary movements. . A quarterly Minimum Data Set (MDS) with a date of 10/10/14 indicated the resident was cognitively intact. The resident had no rejection of care identified. Active diagnoses included temporomandibular joint disorder (TMJ-a disorder that may cause jaw pain). The MDS indicated the resident had no pain in the previous 5 days. The MDS also indicated the resident had mouth or facial pain, discomfort or difficulty with chewing. The care plan, last reviewed on 10/22/14, identified the resident had discomfort or difficulty with chewing with complaints of jaw pain. Approaches to maintain the goal, which was a stable weight, included dental evaluation and intervention as needed. There were no goals or interventions related to the complaints of pain and no care plan for refusal of pain medications. Exercises prescribed by the therapist to relive the jaw pain were not included on the care plan. An interview was held with Nursing Assistant (NA) # 1 on 12/17/14 at 2:30 PM. She stated at times the resident did have complaints of jaw pain. Nurse # 1 was interviewed on 12/17/14 @ 4:37 PM. She stated Resident # 15 had complaints of left jaw pain, usually 1 to 2 times per week. The nurse added the resident refused pain medication and refused to continue the exercises learned through therapy to relive the pain. Nurse # 1 added she would expect pain, persistent TMJ and	F 279	monitor/review 30% of the care plans weekly. (DON) 1/16/15	

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F 279	Continued From page 15 refusal of pain medications to be care planned. The Director of Nursing (DON) was interviewed on 12/18/14 at 9:36 AM. The DON stated she expected dental pain, TMJ or refusal of pain medications to be care planned. The MDS coordinator was interviewed on 12/19/14 at 9:52 AM. He stated the TMJ/pain and refusal of pain medications should have been care planned. The MDS nurse stated while it was not an excuse he was still learning. 4-Resident # 42 was admitted on 11/22/13 with diagnoses that included vascular dementia, Parkinson's disease, cardiomegaly and atrial fibrillation. Progress notes for 7/11/14 at 3:49 PM indicated the resident was upset with his room mate and had threatened to "knock the hell" out of his room mate. Progress notes for 7/14/14 at 11:30 PM indicated staff had been accused of removing clothing from the resident ' s room, while the resident had been seen placing the items in his dresser. On 7/16/14, progress notes indicated the resident was threatening to urinate on the floor because he was upset with staff. The Social Worker (SW) documented on 7/30/14, that a care plan meeting was held for the resident. The SW documented there had been verbal abuse toward the room mate, but no physical abuse. The SW recorded she had counseled the resident on his behaviors.	F 279		

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F 279	Continued From page 16 On 8/24/14 at 7:40 PM, the nurse documented the resident was at the nurse's desk demanding staff put him to bed. The nurse documented she tried to explain staff had other patients and she would let them know of his request. The nurse indicated Resident # 42 had not liked her answer and stated he and his room mate would scream all the way up the hall for staff to help now. The Annual Minimum Data Set (MDS), dated 10/15/14, coded Resident # 42 as moderately cognitively impaired. No moods, behaviors or rejection of care were identified. Behavior had been coded as improved. The care plan, last reviewed on 10/22/14, did not address the resident's verbal abuse or aggressive behavior. There was no care plan that addressed the resident ' s preference to rise at 8:00 AM and retire at 8:00 PM. There were no identified goals or interventions for staff to use when the resident became aggressive. A Monthly Nursing Summary, dated 10/31/14, indicated under Mood and Behavior, that Resident # 42 had issues with anger, repetitive health complaints, repetitive anxious complaints and insomnia. On 11/17/14 at 9:13 PM, the physician wrote the resident was screaming "help" loudly while rolling down the hall. When approached, the resident stated he was supposed to be in bed by 8:00 PM, but the NA had told him he had to wait. The physician noted it was 8:01 PM. The doctor noted this was not the first time the resident had behaved this way.	F 279		

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Nursing Assistant (NA) # 1 was interviewed on 12/17/14 at 2:30 PM. She stated when a resident had behaviors she would try to talk to the resident and then would report the behaviors to the nurse. NA # 1 stated she had no idea where to find interventions to work with residents with behaviors. She stated Resident # 42 had "his moments" adding he would get mad if things did not go his way. The NA identified the resident was verbally abusive at times.

An interview was held with NA # 3 on 12/17/14 at 3:00 PM. Interventions for behavior problems could be found in the computer. NA # 3 added interventions were also verbally relayed from shift to shift. Resident # 42 was identified as having " good days and bad days " . Behaviors for Resident # 42 included disrobing and yelling at his room mate. The NA knew it was the resident ' s preference to be up by 8:00 AM and be in bed by 8:00 PM and added staff tried to comply with his wishes. She stated Resident # 43 got angry when he did not get to bed by 8:00 PM

Nurse # 1 was interviewed on 12/17/14 at 4:30 PM. Nurse # 1 stated Resident # 42 had threatened to hit his room mate, but as far as she knew, there had not been a physical altercation. She stated sometimes, the 2 residents would get into a yelling contest. Nurse # 1 stated it was the resident ' s preference to be in bed by 8:00 PM and if he was not, his behaviors started.

Nursing Assistant # 2 was interviewed on 12/17/14 at 5:00 PM. The NA stated resident behaviors were reported to the nurse. She identified Resident # 42 as cursing and yelling. She added there had been verbal altercations with the room mate. The NA stated the resident '

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F 279	Continued From page 18 s preference was to be in bed by 8:00 PM and she tried her best to have him in bed at 8:00 PM. An interview was held with the Assistant Director of Nursing (ADON) on 12/.17/14 at 5:23 PM. The ADON stated resident behaviors were documented on the antipsychotic flow sheets and in the nurse's notes. The NA has access to the care plan book and information was verbally relayed by the nurse. The ADON stated in-services had been provided to the staff on how to deal with particular behaviors. She stated out of the ordinary behaviors are care planned. The ADON stated Resident # 42 became upset when his needs were not immediately met, adding he liked to go to bed at 8:00 PM and would get upset if it was 8:01 PM. The ADON stated she thought the behaviors and personal preference for Resident # 42 should be care planned. Review of the care plan by the ADON revealed the resident ' s behaviors and preferences had not been care planned. An interview was held with the Director of Nursing (DON) on 12/18/14 at 9:25 AM. She stated resident behaviors were documented in the nurse's notes. The DON stated the expectation was for behaviors and for specific care needs of the resident to be care planned. The DON stated at times, Resident # 42 ' s room mate would block the door way. She stated the two have had verbal altercations, but no physical altercations. The DON added Resident # 42 had threatened to hit his room mate. An interview was held with the Social Worker (SW) on 12/19/14 at 10:07 AM. The SW stated she started at the facility on 11/13/14, but had	F 279		

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previous experience with care planning. The SW stated any behaviors and personal preferences should be care planned. She added she was unaware Resident # 42 had behaviors or personal preferences.

5-Resident # 43 was admitted on 5/23/14 with diagnoses that included chronic kidney disease requiring hemodialysis.

Review of the resident ' s care plan, last reviewed on 12/17/14, revealed dialysis and interventions to prevent problems associated with dialysis had not been care planned.

The Assistant Director of Nursing (ADON) was interviewed on 12/17/14 at 5:13 PM. She stated she expected to see dialysis with interventions to prevent complications care planned. The ADON reviewed Resident # 43 ' s care plan and acknowledged dialysis had not been care planned.

The Director of Nursing (DON) was interviewed on 12/18/14 at 9:08 AM. The DON stated she expected dialysis with appropriate goals and interventions to be care planned

The Minimum Data Set (MDS) Coordinator was interviewed on 12/19/14 at 9:47 AM. He stated he decided what to care plan by items that triggered on the MDS and any other issues that came up. He stated he knew dialysis should have been care planned. The MDS nurse stated he had no excuse for not care planning dialysis, other than he thought the nurses knew what to do for a dialysis resident without a care plan. He added he had been responsible for the MDS and care plans for 6 months and had not received any

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F 279	Continued From page 20 formal training. 6. Resident #19 was re-admitted to the facility on 10/18/2014, with diagnosis to include cyclothymic disease which is a mood disorder, depression, anxiety, mood lability, and late effects of a stroke. Her comprehensive minimum data set (MDS) assessment dated 9/29/2014 revealed severe cognitive impairment. A review of Residents #19's Medication Administration Record (MAR), included medications for depression, antianxiety, and antipsychotic. Resident #19's care plan documented a problem dated 1/1/2014 for agitation /anxiety. The Goal Target Date was last noted for 1/2/2015, stating "Resident will have decreased episodes of anxiety on an on-going basis." The interventions read "1. Administer Ativan, (and antianxiety medication) 0.5 milligrams (mg) every evening per order. 2. Administer Seroquel, (an antipsychotic medication) 50mg every evening and 25mg at 1:00 PM daily - monitor for target behaviors and record. #4. Monitor behaviors and record every shift." The target behaviors to monitor were not listed on the residents care plan. On 12/17/2014 at 3:01 PM, an interview was conducted with Nursing Assistant #5 (NA). NA stated Resident #19 is usually calm and good natured and does not have behaviors that she is aware of. The Activities of Daily Living (ADL) book informs the nursing assistants of what care residents require. No target behaviors were listed in the ADL book for Resident #19. NA stated that if she noticed a change in behavior, she would notify the nurse. An interview was conducted with Nurse #3 on	F 279		

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F 279	Continued From page 21 12/17/2014 at 11:22 AM. The Nurse stated that Resident #19 had a lot of complaints and had even yelled at the staff, but that had been in the past. The nurse stated that since the Resident had come back to the facility after having hernia surgery in October, she had been pleasant to staff. Her medications had not changed and she was cooperative with her care. On 12/18/2014 at 10:45 AM, an interview was conducted with the MDS nurse, who writes the care plans. The MDS nurse stated that the target behaviors were for anxiety and agitation, which meant that the resident was impatient and fidgety, and that is what the nursing assistants would be looking for. The MDS nurse did not think the care plan needed additional clarification.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		1/16/15

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise care plans to reflect new interventions to prevent falls for 2 of 3 residents (Residents #43 and #47) reviewed for falls. 1. Resident # 43 was admitted on 5/23/14 with diagnoses that included chronic kidney, stroke with left paralysis, diabetes, anemia and chronic pain. On 5/24/14 at 12:58 AM, nursing progress notes indicated Resident # 43 attempted to sit on the side of the bed without assistance and slid to the floor. The nurse documented she reminded the resident to call for assistance. A therapy evaluation was also used as an intervention. A physical therapy evaluation, dated 5/27/14, indicated the resident needed assistance with transfers and indicated Resident # 43 required minimum assistance of 1 sit to stand and stand pivot to bed/chair. On 5/31/14 at 2:33 AM, nursing progress notes indicated the resident was found on the floor in the bathroom of his room sitting upright between the toilet and the wall. No walker, cane or other device was seen at the site of the fall. The intervention was to reorient Resident # 43 to the use of the call bell system and reminded to call for help. The resident ' s care plan, with a start date of	F 280	A.The requirement will be met as evidenced by documentation in the resident's Electronic Medical Record (EMR) by the social worker and/or the MDSC that they are invited to attend and assisted to care conference as needed. There will be documentation in the EMR that the resident's family, RP, or legal representative was invited to attend. The Care Conference sheet will be signed by anyone attending care conference. The social worker is ultimately responsible for ensuring that residents are in attendance at care conference if they wish to attend and/or able to do so or their RP is present for them. 12/29/14 This requirement has been met to reflect changes and revision in the care plan by the MDSC for residents #43 and #47 related to falls and added the use of gripper socks for non-slippage. (1/16/15) The Morse Fall Scale was updated by the MDSC for resident #43 on 1/13/15 with a score of 65 indicating high risk for falls and Morse Fall Scale updated by MDSC on 1/16/15 for resident #47 with a score of 75 indicating high risk for falls. B. Corrective action will be accomplished for those residents having potential to be affected by the same practice by the following; the MDSC will review any incident reports on a daily	

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F 280	Continued From page 23 6/5/14, identified the resident as a risk for falls. The goal of remaining free from injury was to be achieved by giving the resident verbal reminders not to ambulate or transfer without assistance, keeping the bed in a low, locked position, keeping the call light in reach at all times, placing the resident in a fall prevention program and transfer by sit to stand lift. The care plan did not identify the two actual falls on 5/24/14 and 5/31/14. The care plan did not include the therapy information from 5/27/14 that Resident # 43 could stand/pivot with the assistance of staff. The Quarterly Minimum Data Set (MDS), dated 9/5/14, indicated Resident # 43 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The resident was coded as requiring total assistance for transfer. On 9/24/14 at 1:20 PM, the nurse documented on the Incident report, that Resident # 43 attempted to get off the bedside commode without assistance. Once standing, the resident fell to the floor on his knees with his upper body in the seat of the wheelchair. The intervention to prevent the reoccurrence was to encourage the resident not to get up without assistance. The care plan did not include any new interventions to prevent further falls. Review of progress notes and an Incident Report for 12/15/14 at 6:03 AM, indicated the resident had been found on his knees by the bed. The resident stated he had fallen/slid off the bed. The nurse documented the intervention was to remind the resident to use his call bell. On the back of the Incident Report, the nurse had written the resident over-estimated his ability and forgets	F 280	basis. Changes will be made in the care plan to reflect new interventions, including the use of gripper socks, assistive devices such as walkers, canes,or wheelchairs for residents with falls. The Certified Nursing Assistant (CNA) ADL Nursing Instruction sheet will be updated by either the MDSC, licensed floor nurses, Assistant Director of nursing or the Director of Nursing so information is relayed to the CNAs on a daily basis. A list of residents who are at risk for falls has been placed in the CNA daily assignment book and is updated as needed with additions or deletions as needed based on incident reporting. (12/29/14) C.The Morse Fall Scale (MFS) will be done on admission, quarterly, and as needed to determine the resident's fall risk. MDSC is responsible for reviewing the MFS after each fall making changes as needed to the care plan. The MDSC is also responsible for ensuring that all staff is aware of the resident's fall risk. This has been accomplished by updating CNA ADL Nursing Instruction sheets, conveying information to the 24 hour report as needed and a current list of the residents who are at fall risk has been placed at the nurse's station and in the CNA assignment sheet. Nursing staff have been made aware of these changes by on-going communication by the MDSC and the Assistant Director of nursing. In addition information is relayed to the CNAs through daily change of shift reports. (Licensed floor nurses, MDSC, ADON) 1/16/15 D.Compliance for attendance at care plan	

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F 280	Continued From page 24 to use his call bell. Under equipment the nurse documented the resident did not have appropriate footwear and was only wearing socks. The care plan was not revised to reflect interventions to include proper footwear and did not reflect the resident ' s forgetfulness. . The Assistant Director of Nursing (ADON) was interviewed on12/17/14 at 5:13 PM. The ADON stated when a resident fell, nurses were expected to complete an assessment for injury, notify the family and doctor, complete an incident report and place an intervention to prevent more falls. She stated, if possible, a new intervention was expected with each fall; adding sometimes all is done that can be done. Interventions for Resident # 43 included reminding him to call for assistance, making sure the call light was within reach, reminding him to lock wheelchair, making sure the bed was locked. The ADON stated these were the same interventions as used for all residents. On 12/18/14 at 9:08 AM, the Director of Nursing (DON) was interviewed. The DON stated she expected nurses to assess residents for injury after a fall. Additionally, the nurse was expected to investigate the cause of the fall and interventions placed to prevent further occurrences. The care plan is expected to be revised within 24 hours with the new interventions added. New interventions are relayed to staff by word of mouth. The DON stated the incident report for 5/31/14 was not found. She added she saw which nurse documented the note about the fall and was not surprised there was no incident report. An interview was held with the DON on 12/19/14	F 280	conference by resident and/or responsible party will be monitored on a weekly basis with 100% of the care plans due for that week's care conference reviewed using the Resident Care plan Cover Sheet to determine attendance. Threshold is 80% attendance by resident or responsible party. Results of review will be presented to the Quality Assurance Committee monthly for a period of 3 months and quarterly thereafter. (Social Worker) 1/16/15 Compliance for revision of care plans will be monitored on a weekly basis. The DON will monitor/review 30% of the care plans weekly. Report will be submitted to the Quality Assurance Committee monthly for 3 months and then quarterly thereafter. The MDS Review Checklist will be used to compile the information. Findings, trends, and any problems identified with corrective action will be reported at the QA meeting. (DON or ADON) 1/16/15	

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F 280	Continued From page 25 at 8:48 AM. The four falls Resident # 43 sustained were reviewed. The DON stated the intervention for the 5/23/14 fall had been a therapy referral. Intervention for the 5/31/14 fall had been documented in the nurse ' s notes since there was no Incident Report and investigation. The nurse had documented she reminded the resident to use the call bell. The DON stated after she reviewed the 9/24/14 fall, it was determined the intervention was to check frequently, which means every 2 hours. This check was not documented since it was no different care than was expected for any other resident. The DON reviewed Resident # 43 ' s fall and determined the intervention was to encourage the use of the call bell. The DON stated non-skid strips by the bed and non-skid socks would have been appropriate interventions for Resident # 43, but she had not thought of those interventions. The MDS Coordinator was interviewed on 12/19/14 at 9:47 AM. He stated he decided to care plan by items that triggered on the MDS and any other issues that came up. He stated he had no excuse for not revising the care plan, except he had been doing MDS and care plans for 6 months and had no formal training. 2. Resident #47 was readmitted to the facility on 6/17/14. Diagnoses included dementia, psychotic disorder, hypertension and diabetes. The admission Minimum Data Set (MDS) dated 6/26/14 revealed that Resident #47 was severely cognitively impaired; was independent with bed mobility, transfers, ambulation in room; had unsteady balance moving from seated to standing position, walking and turning but was able to	F 280		

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F 280	Continued From page 26	F 280		

stabilize without staff assistance; was steady moving from on and off toilet and with surface-to-surface transfer; was occasionally incontinent of urine, always continent of bowel and had 1 fall without injury in the last 2-6 months.
The Care Plan dated 6/2/14included risk for falling related to history of falls. Interventions included to place in a fall prevention program. The goal was to reduce the risk of injury related to falls through 1/2/15.
No falls were documented until 10/16/14 at 6:14 AM the nurse ' s notes revealed Resident #47 was found lying on the floor on his right side next to the bed. The notes indicated the resident said the bed moved when he tried to sit down, and it was observed the bed had been moved and the wheels not locked. The resident was observed to be lying in urine. No injury was found. The incident report dated 10/16/14 did not list any steps to be taken to prevent recurrence.
An incident report dated 12/1/14 at 12:20 AM revealed Resident #47 was found on the floor in front of his chair. No injury was noted. Steps taken to prevent recurrence included to encourage the resident to lie down when sleepy. The Care Plan was not updated.
An incident report dated 12/13/14 at 2:50 PM and written by Nurse #2 indicated Resident #47 was found on the floor in the bathroom with his pants down, no injuries. Steps taken to prevent recurrence included, " Remind to ask for assistance when needed. " The Care Plan was not updated.
An incident report dated 12/17/14 at 6:30 AM revealed Resident #47 was found on the floor in front of the bathroom door without anything on his feet, and had an abrasion to his right ankle. Actions listed included: to be screened by

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F 280	Continued From page 27 physical and occupation therapies, speech therapy for cognition and raised toilet seat. The Care Plan for falls was updated on 12/17/14 with the following interventions: keep bed in lowest position with brakes locked, call light in reach at all times, keep personal items and frequently used items in reach, proper footwear, and environment free of clutter. An interview was conducted with NA #6 on 12/17/14 at 8:50 AM. She indicated she was not aware of any particular safety needs of Resident #47. On 12/18/14 at 2:06 PM an interview was conducted with Nurse #2. She stated that she recalled Resident #47 ' s fall on 12/13/14 and that she had no idea what happened. The nurse said no new interventions were indicated based on the fall. Nurse #2 recalled the resident was barefoot and that he takes off his shoes and socks during the day. Nurse #2 stated residents at risk for falls were put on a falls program. She explained the program is whatever is in the falls Care Plan. During an interview on 12/18/14 at 2:44 PM, the MDS nurse indicated all residents were considered at risk for falls. The MDS nurse indicated that after a fall he would update the Care Plan with the next quarterly assessment. The MDS nurse indicated he saw all incident reports and kept a record of who had fallen each month and if there was an injury. During an interview on 12/19/14 at 12:33 PM, the Director of Nursing (DON) stated any new interventions should be care planned immediately.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		1/16/15

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F 309	Continued From page 28 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to assess the dialysis access site following dialysis for complications from dialysis treatment to include active bleeding, redness or dislodgement of the dressing for 1 of 1 sampled residents (Resident # 43) reviewed that received dialysis. Findings included: Resident # 43 was admitted on 5/23/14 with diagnoses that included chronic kidney disease requiring dialysis three times weekly. The Quarterly Minimum Data Set (MDS), dated 9/5/14, indicated Resident # 43 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. Dialysis was not coded under Special Treatments. Review of the nurse ' s progress notes did not reveal any notes that documented a bruit/thrill or condition of Resident # 43 ' s dialysis access site after return from dialysis Nursing Assistant (NA) # 1 was interviewed on 12/17/14 at 2:20 PM. The NA stated she did nothing special for Resident # 43 when he returned from dialysis. She stated vital signs were not taken until the next shift arrived no	F 309	A. For resident #43 and other residents receiving dialysis, the requirement will be met as evidenced by daily documentation on the resident's Treatment Administration Record, of the hemodialysis site according to the "look, listen, feel" approach. The physician will be notified immediately of signs of infection or absence of the thrill or bruit. (Assistant Director of Nursing or Director of Nursing) (1/16/15) B. Corrective actions to be taken for those residents found to have the potential to be affected by the same practice: 1. Nursing staff will adhere to the Hemodialysis Site Policy which was in-serviced by the ADON to the nursing staff, to ensure routine monitoring and surveillance of the resident's access site on each shift. The site will be assessed for signs of infection, presence of a thrill/bruit and for signs of bleeding. Assessment findings will be documented on the resident's Treatment Administration Record and in the Electronic Medical Record in patient care notes. Any abnormalities will be reported to the	

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F 309	Continued From page 29 matter if the resident returned at 1:00 PM or 3:00 PM.. Nurse # 1 was interviewed on 12/17/14 at 4:25 PM. The nurse stated Resident # 43 went to dialysis three times a week. Nurse # 1 added, Resident # 43 usually returned to the facility from dialysis between 1:00 PM and 3:00 PM. Nurse # 1 added his return from dialysis was during her shift. The nurse stated when Resident # 43 returned from dialysis, she made sure he was feeling ok, offered his meal tray and assisted him to the bathroom. She stated his dialysis access site was covered with a pressure dressing. The nurse stated the resident ' s bruit and thrill (signs found at the access site that indicated the dialysis access site was functioning properly) were assessed daily and documented in the nurse ' s notes. The nurse reviewed the nurse ' s notes and acknowledged there was no documentation that revealed the resident ' s condition or the condition of his dialysis access site on return from dialysis. The Assistant Director of Nursing (ADON) was interviewed on 12/17/14 at 5:19 PM. She stated nurses were expected to give medications and the meal on a resident ' s return from dialysis. The ADON added nurses were also expected to check the dialysis access site daily and document those findings in the nurse ' s note. The ADON stated this would be important to make sure the access site was working properly. Even with a pressure dressing over the access site, nurses were expected to make sure the dressing was dry and intact when a resident returned from dialysis. The ADON stated there was no system in place at the facility for reviewing notes and assuring assessments for dialysis access sites had been	F 309	physician immediately. (1/16/15) C. Measures which have been put into place to ensure practice will not occur: Assistant Director of Nursing or Director of Nursing will check Treatment Administration Record (TAR) Daily to ensure documentation is being done and hemodialysis site is being monitored by licensed nursing staff 2 times per day on the 7Am-7PM shift and on the 7PM-7AM shift. A Hemodialysis Site spread sheet will be used to document the findings. The sheet includes the resident's name, date, site checked by (nurse), documentation on the TAR and nurse reviewer. (DON or ADON)1/16/15 2. Compliance with the policy will be monitored weekly by the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) through review of the Treatment Record daily and use of the audit tool, Hemodialysis Site spread sheet which includes resident name date, site checked by (nurse),documentation on TAR (yes) (no) and Nurse Reviewer. (1/16/15 D.Results of the audit/review will be reported to the Quality Assurance Committee with findings, trends, problems and corrective actions for a period of 3 months and then quarterly thereafter. 100% of the dialysis resident's TAR will be reviewed each day with threshold of 100% expected. (DON or ADON 1/16/15)	

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F 309	Continued From page 30 completed as expected. The Director of Nursing (DON) was interviewed on 12/18/14 at 9:08 AM. She stated when a resident returned from dialysis the expectation was for the nurse to assess the resident. The assessment would include vital signs and observation of the access site. If a dressing was present, the DON stated the nurse should check the dressing for bleeding. The DON added a resident ' s bruit and thrill should be assessed every shift and documented in the nurse ' s notes. The DON stated she reviewed the nurse's notes last night and did not find any evidence the nurses had been assessing Resident # 43 ' s dialysis access site on return from dialysis.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and review of the medical record, the facility failed to provide incontinent care for 1 of 4 residents (Resident # 15), reviewed for personal care. Findings included: Resident # 15 was admitted on 1/31/07 with diagnoses that included hypertension, seizures,	F 312	It is the policy of this facility that incontinent care will be provided after each incontinent episode to promote good hygiene, reduce risk of infection, help maintain skin integrity, and eliminate odor. Incontience Policy has been in-serviced and reviewed will nursing staff and is kept in the policy manual at the long term care nurse's desk. (1/15/15)	1/16/15

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F 312	Continued From page 31 arthritis and involuntary movements. The most recent Minimum Data Set (MDS), a quarterly dated 10/10/14, indicated the resident was cognitively intact. She did not have any behaviors or rejection of care identified. Resident # 15 was coded as incontinent of bowel and bladder and was identified as requiring total assistance for personal hygiene, bathing and toilet use. The care plan, last reviewed on 10/22/14, identified Resident # 15 as at risk for skin breakdown due to incontinence and impaired mobility. Interventions to reduce the risk of skin breakdown included keeping the skin as clean and dry as possible, minimizing skin exposure to moisture, providing incontinent care after each incontinent episode and turn and position every 2 hours. On 12/17/14 at 11:00 PM, an observation was made of Nursing Assistant (NA) # 1 providing morning care for Resident # 15. When the NA removed the resident ' s brief, a very strong urine odor was present. The NA removed the brief and placed the resident on her left side. Beneath the resident and under the brief, the pad that was laying on top of the bottom sheet appeared wet with a light brown ring approximately 1 inch in width visualized. An interview was held with NA # 1 on 12/17/14 at 2:30 PM. The NA acknowledged the strong urine odor and acknowledged the wet pad with the brown ring. She stated prior to the 11:00 AM bath, she had not checked on the resident or provided incontinent care since the start of her shift at 7:00 AM. NA # 1 stated the reason she	F 312	A. For resident #15 and all other residents requiring incontinent care the following measures will be put into place to ensure that care is provided to each resident in a timely manner. 1. Nursing staff will document continence status, type (fecal/urinary) and assistance needed in the medical record for new admissions and throughout their stay in long term care as needs change. 2. The Minimum Data Set Coordinator (MDSC) will address continence status, toileting needs, and assistance needed to care for incontinent residents. The nursing staff and the MDSC will update the care plan as needed to ensure interventions are current and reflective of the resident's needs. B. Residents with incontinence will be checked every 2 hours by their assigned CNA for incontinence needs and care will be provided to those that are found to be soiled. Residents that are continent/partially continent but need assistance to toilet will be offered toileting assistance every 2-3 hours and as needed or requested. Licensed nursing staff is responsible for providing supervision of care provided by CNAs to ensure adequate and timely care is given. Hall nurse on duty will make rounds at least 4 times during their 12 hour shif to observe residents needs and supervise CNA quality of care. The nursing staff will document on the Ambassor Checklist their findings with focus on incontinent	

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F 312	Continued From page 32 had not provided incontinent care for Resident # 15 was because she was bathing other residents. The NA stated she had no idea the last time Resident # 15 had received incontinent care. The NA added she was aware untreated incontinence could cause skin breakdown. An interview was held with Resident # 15 on 12/17/14 at 2:55 PM. She stated she was unsure what time she had received incontinent care, but knew it was before 7:00 AM. An interview was held with the Assistant Director of Nursing (ADON) on 12/17/14 at 5:28 PM. The ADON stated it was expected residents would be checked every 2 hours and incontinent care provided as needed. The ADON added if a pad was found with a brown ring, then it had probably been hours since the resident received incontinent care. The Director of Nursing (DON) was interviewed on 12/18/14 at 9:36 AM. The DON stated the expectation was for residents to be checked every 2 to 3 hours. She stated in in-services, NA ' s are told every 2 hours, but to not let more than 3 hours pass without checking on residents. The DON added for the incontinence to saturate the brief and to leave a brown stain on the pad, the incontinence had been there for " a while " .	F 312	care for resident #15 and all other resident who could potentially be affected. Any problems encountered by the hall nurse(s) will be corrected and the Director of Nursing will be made aware. 1/16/15 D. Compliance with incontinent care will be monitored through ambassador rounds which are done on a daily basis to check rooms and residents for quality of care, which includes incontinence care, safety and environmental issues. Ambassadors are members of the nursings staff: MDSC,ADON, Staff Development Coordinator, the Activity Director and the Social Worker. A report will be presented to the Quality Assurance Committee Meeting with results of the ambassador rounds including problems encountered, corrective action taken and with recommendations if compliance is less than 90%. Findings of the report compiled will be reviewed and utilized to improve care through education of the nursing staff for any problem area. (Staff Development Coordinator (SDC)	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		1/16/15

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F 323	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to place interventions to prevent falls for 2 of 3 residents reviewed for falls (Residents # 43 and # 47). Findings included: 1. Resident # 43 was admitted on 5/23/14 with diagnoses that included congestive heart failure and stroke with left sided paralysis. Review of a nursing progress note dated 5/23/14 at 6:05 PM, indicated the resident could stand and transfer with one assist and a quad cane (a cane with 4 prongs for stabilization), able to push/pull self up in bed with right side and moderate assistance required for activities of daily living. The Fall Scale, dated 5/23/14, Resident # 43 was at a high risk of falling. The scale indicated the resident had a fall history within the last 3 months, was weak and required ambulatory aids. On 5/24/14 at 12:58 AM, nursing progress notes indicated the resident attempted to sit on the side of the bed without assistance and slid to the floor. Interventions included reminding him to ask for assistance and a therapy evaluation. A physical therapy (PT) evaluation, dated 5/27/14 indicated the resident had difficulty walking, gait	F 323	It is the policy of this facility to provide adequate supervision and assistive devices to minimize accidents to be affected. For resident #43, care has been updated to include the use of gripper socks to prevent slipping on floor A. For resident #43 corrective action has been accomplished by revision/update of care plan to include the use of gripper socks for non slippage. Bed is in lowest position and locked to prevent it from moving and causing resident to potentially fall. For resident #47 corrective action has been accomplished by revision/update of care plan for use of gripper socks, checking for toileting needs every 2-3 hours, and providing minimum to moderate assistance for ambulation as needed. MDSC 1/13/15 and 1/16/15 B. Corrective action will be accomplished for those residents having potential to be affected by the same practice with the following: 1)Morse Fall Scale will be done on admission and quarterly for all residents. Those residents with a score of 25 or greater are considered at risk for falls and care plan will be initiated with interventions to include fall mat to floor, low bed or bed in lowest postion, gripper	

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F 323	Continued From page 34 abnormality and lack of coordination. The evaluation indicated the resident needed assistance with transfers. The evaluation indicated the resident was appropriate to receive skilled therapy based on the results of the evaluation. Review of the therapy section revealed no further notes that indicated the resident received therapy. A rehabilitation progress note, dated 5/27/14, indicated a PT examination was performed and the patient was educated for expected course of approval for treatment, safety awareness and importance of the patient to perform all movement of the left side as he can possibly muster. On 5/31/14 at 2:33 AM, nursing progress notes indicated Resident # 43 was found on the floor in the bathroom of his room sitting upright between the toilet and the wall. No walker, cane or other device was seen at the site of the fall. The intervention listed was to reorient the resident to the use of the call bell and remind him to call for help. A care plan, with an onset date of 6/5/14, indicated Resident # 43 was at risk of falls related to a history of falls. Approaches to prevent injury with the falls included giving the resident verbal reminders not to ambulate or transfer without assistance, keeping the bed in a low, locked position, keeping the call bell in reach, transfer the resident with a sit to stand lift and placing the resident on a fall prevention program. The Quarterly Minimum Data Set (MDS), dated 9/5/14, indicated the resident had short and long term memory impairment with severely impaired	F 323	socks, assistive/mobility devices as needed such as wheelchairs, walkers, cane , rolling walker or quad cane. 2.Referrals will be made to physical therapy. occupation therapy or to speech therapy if there are cognitive issues. 3. Quarterly medication review at the time of care conference to identify medications having potential adverse affects associated with falls. This will be accomplished at quarterly care conference with the interdisciplinary team, including the physician and with input from the consultant pharmacist. C. Measures which have been put into place to ensure that the practice does not occur or affect other residents the following will be done: 1. Identification of residents at risk for falls through use of Morse Fall Scale 2. Ambassador rounds daily checking environment for any potential hazards. T 3. Review of all incident reports at weekly Risk Management meeting with findings, including trends, recommendations and corrective action(s) taken if applicable. (Reported by DON weekly) 12/19/14 D. A detailed report will be submitted by the DON each month to the Quality Assurance Committee. The report includes the number of incidents per month, trends (occurrence by shift,time of day, repeated falls for same resident), number of injuries related to falls and the corrective action(s) taken. (Director of Nursing)	

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cognitive skills for daily decision making. The resident was coded as requiring total assistance for transfer. No falls were captured on the assessment.

On 9/24/14 at 1:20 PM, the nurse documented on an incident report that Resident # 43 attempted to get off the bedside commode without assistance. Once standing, the resident fell to the floor on his knees with his upper body in the seat of the wheelchair. The nurse documented the intervention used to prevent reoccurrence was to encourage the resident not to get up without assistance.

Review of the Incident/Accident Report indicated Resident # 43 fell on 12/15/14 at 6:03 AM. Under description, the nurse had documented she answered the call light to find resident on his knees. The nurse also documented the resident claimed he slid/rolled out of bed. Under Additional Comments, the nurse had written steps taken to prevent reoccurrence were to encourage the resident to call for assistance before rising. On the back of the sheet, the nurse had written the resident is working with restorative on ambulation, but was not independent. She added he over-estimated his ability and forgets to use his call bell. The nurse determined the resident was trying to get into his wheelchair without help, per report of the 11-7 shift. Under equipment the nurse documented the resident did not have appropriate footwear and was only wearing socks.

Review of the care plan indicated a handwritten date of 12/15/14 with the word " fall " placed by the date.

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An interview was held with Nursing Assistant (NA) # 1 on 12/17/14 at 2:20 PM. She stated fall risk was listed on the resident care plan. She added that all residents that lived on Resident # 43 ' s hall were at a high fall risk. NA # 1 stated Resident had only had 1 fall that she was aware. The NA added interventions used to prevent falls for Resident # 43 included telling him to ring his call bell and not get up by himself. She stated she could think of no other interventions.

An interview was held with NA # 3 on 12/17/14 at 3:02 PM. The NA identified Resident # 43 as a fall risk. She stated when a resident was a fall risk they needed assistance with transfers. The NA added Resident # 43 tried to get up alone. Interventions that NA # 3 used for Resident # 43 included checking on him periodically, making sure the call bell was close and instructed him to call if he needed something. The NA added a symbol on the door alerted staff that Resident # 43 was a fall risk.

Nurse # 1 was interviewed on 12/17/14 at 4:19 PM. Residents on fall precautions are identified by the yellow star outside their door. Reports on residents at fall risk are also verbally reported to staff. The nurse identified Resident # 43 as a high fall risk for falls. Interventions placed to keep Resident # 43 fall free included assisting with daily care and transfers, using a cane during transfer and keeping his call bell within reach. The nurse stated the resident ' s cognition was hard to determine since verbal communication was difficult. She added she did not know if he understood verbal instruction.

On 12/17/14 at 5:00 PM, NA # 2 was interviewed. She stated residents on fall precautions were

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identified by a band on their wrist and on the care plan. She added there was also a fall precaution sign in the resident ' s room. She stated Resident # 43 was at a high fall risk. The NA added although instructed not to, the resident continued to transfer independently.

The Assistant Director of Nursing (ADON) was interviewed on 12/17/14 at 5:13 PM. She stated fall assessments were done on admission, quarterly and as needed for resident status changes. The ADON added when a resident fell, nurses were expected to assess, complete an incident report, notify the physician and family and notify the next shift. Additionally, an intervention should be placed to prevent the fall from reoccurring. Sometimes, the ADON added, new interventions were not possible since all was being done that could be done to prevent falls. The ADON stated reminders and education was appropriate for cognitively impaired residents depending on the level of impairment. The ADON added Resident # 43 ' s fall prevention interventions included reminding him to call for assistance, making sure his call light was within reach, reminding him to lock his wheelchair and keep the bed locked. The ADON stated these were the same interventions used for all residents.

The Director of Nursing (DON) was interviewed on 12/18/14 at 9:08 AM. The DON stated after a resident fell, nurses were expected to assess the resident, investigate to find the cause of the fall, notify the physician and family and place interventions to prevent the incident from occurring again. The DON added education and reminders were not appropriate for a cognitively impaired resident. The DON added Resident #

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43 received a therapy evaluation after his first fall, but did not receive ongoing therapy because his payor source would not reimburse the facility for the therapy. Instead, the resident was placed in the restorative program where he remained. The MDS information was reviewed. The DON stated she did not think the resident was cognitively impaired and believed he understood instruction. Fall precautions used for Resident # 43 included a falling star on the door and a low bed. The DON stated the resident ' s care plan for falls was expected to be revised at least within 24 hours after the fall with new interventions. New interventions are relayed to staff by word of mouth. The DON stated the incident report for 5/31/14 was not found.

Nurse # 2 was interviewed on 12/18/14 at 4:30 PM. She stated the Resident Care Cards were used by the NA's to provide care to the residents, including information about fall risks. She was unsure who was responsible for updating the cards. The nurse reviewed the resident care card for Resident # 43 and stated there were no interventions or identification of fall risk for this resident.

The ADON was interviewed on 12/18/14 at 5:05 PM. The ADON reviewed the care card for Resident # 43 and acknowledged he had not been identified as a fall risk and fall prevention interventions were not included.

An interview was held with the DON on 12/19/14 at 8:48 AM. The DON reviewed all the falls for Resident # 43 and acknowledged other than the therapy referral he had not received any interventions for his falls. The DON added falls were discussed at the at risk meeting. The DON

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stated Resident # 43 was not considered a frequent faller so therefore he may not be discussed at every risk meeting. The DON stated falls were tracked by times and shifts.

An interview was held with the Physical Therapist (PT) on 12/19/14 at 9:07 AM. The therapist reviewed the evaluation for Resident # 43 and stated he was found to need moderate assistance of 1 to sit to stand with a walker. The therapist defined moderate assistance as the resident does 50% and requires 50% assistance. He added Resident # 43 was seen on 5/27/14 for the evaluation and he developed a plan of care to see the resident for 5 times a week for 4 weeks. The therapist reviewed the resident ' s medical record and stated he did not find any other therapy notes. He stated his guess was the resident was not approved by his payor source for therapy. He added unless he's asked to, during a physical therapy screen, to develop a restorative program, he doesn ' t develop a program. The therapist stated he did not remember working with the restorative aide to develop a restorative program for Resident # 43.

An interview was held with NA # 4 on 12/19/14 @ 9:26 AM. NA # 4 was the restorative aide. She stated she had been working with Resident # 43 since June 2014 since therapy did not treat him. She stated she worked with the resident three times a week, unless there was an activity scheduled. If there was an activity scheduled, the resident did not receive restorative treatment. The restorative aide stated the resident had improved from requiring 2 for transfer to being able to transfer independently. She stated she encouraged Resident # 43 to do as much for himself as he could, including transferring

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F 323	Continued From page 40 independently. 2. Resident #47 was readmitted to the facility on 6/17/14. Diagnoses included dementia, psychotic disorder, hypertension and diabetes. The admission Minimum Data Set (MDS) dated 6/26/14 revealed that Resident #47 was severely cognitively impaired; was independent with bed mobility, transfers, ambulation in room; had unsteady balance moving from seated to standing position, walking and turning but was able to stabilize without staff assistance; was steady moving from on and off toilet and with surface-to-surface transfer; was occasionally incontinent of urine, always continent of bowel, had 1 fall without injury in the last 2-6 months; and medications received in the last 7 days included antipsychotic, antidepressant and diuretic. The Care Plan dated 6/2/14included risk for falling related to history of falls. Interventions included to place in a fall prevention program. The goal was to reduce the risk of injury related to falls through 1/2/15. No falls were documented until 10/16/14 at 6:14 AM the nurse ' s notes revealed Resident #47 was found lying on the floor on his right side next to the bed. The notes indicated the resident said the bed moved when he tried to sit down, and it was observed the bed had been moved and the wheels not locked. The resident was observed to be lying in urine. No injury was found. The incident report dated 10/16/14 did not list any steps to be taken to prevent recurrence. An incident report dated 12/1/14 at 12:20 AM revealed Resident #47 was found on the floor in front of his chair. No injury was noted. Steps taken to prevent recurrence included to encourage the resident to lie down when sleepy.	F 323		

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F 323	Continued From page 41 An incident report dated 12/13/14 at 2:50 PM and written by Nurse #2 indicated Resident #47 was found on the floor in the bathroom with his pants down, no injuries. Steps taken to prevent recurrence included, " Remind to ask for assistance when needed. " An incident report dated 12/17/14 at 6:30 AM revealed Resident #47 was found on the floor in front of the bathroom door without anything on his feet, and had an abrasion to his right ankle. Actions listed included: to be screened by physical and occupation therapies, speech therapy for cognition and raised toilet seat. The Care Plan for falls was updated on 12/17/14 with the following interventions: keep bed in lowest position with brakes locked, call light in reach at all times, keep personal items and frequently used items in reach, proper footwear, and environment free of clutter. On 12/17/14 at 8:32 AM, Resident #47 was observed being changed by Nursing Assistant (NA) # 6 and NA #1. The bed was low and locked. Socks and athletic shoes were donned. No clutter was observed. An interview was conducted with NA #6 on 12/17/14 at 8:50 AM. She indicated she was not aware of any particular safety needs of Resident #47. On 12/18/14 at 2:06 PM an interview was conducted with Nurse #2. She stated that she recalled Resident #47 ' s fall on 12/13/14 and that she had no idea what happened. The nurse said no new interventions were indicated based on the fall. Nurse #2 recalled the resident was barefoot and that he takes off his shoes and socks during the day. Nurse #2 stated residents at risk for falls were put on a falls program. On 12/18/14 at 3:24 PM, the Assistant Director of Nursing (ADON) indicated that falls were	F 323		

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F 323	Continued From page 42 reviewed during interdisciplinary team meetings. Reviews included determining why the resident fell and can any interventions be added. The ADON stated a raised toilet seat was added at one point. The ADON said that no particular cause for the falls had been identified and the facility did not know what more to do.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to put nutritional interventions in place to prevent continued weight loss for 2 of 4 residents (Resident # 10 and Resident # 45) reviewed for weight loss. Findings included: The Weight Loss policy, revised on 1/23/12, indicated unplanned weight loss was not acceptable. Under Procedure, the policy indicated weights would change from monthly to weekly with any noticeable weight loss. The	F 325	A. Resident #10 placed on weekly weight monitoring. Med-pass Nutrition supplement started 12-29-14 3x/day providing 540 calories. PO-intake continues at 50-75% daily. Total feed by family or nursing staff. Care plan updated to show weight monitoring and nutrition supplement added. Ice cream added on lunch and dinner trays. Weight loss/gain assessment started on 12-22-14. Progress present at the At Risk Meeting along with any recommendations from nursing, RD, or MD. Speech Language	1/16/15

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F 325	Continued From page 43 policy also indicated if a resident had a 5 pound increase or decrease, a reweight would be obtained the next day. Resident # 10 was admitted to the facility on 5/6/13 with diagnoses that included hypertension, generalized pain, hypothyroidism, and arthritis. Vital sign record indicated the resident's weight on 8/8/14 was 152 pounds. During September 2014, the resident's weight was recorded as 160 pounds and in October 2014, Resident # 10's weight was recorded as 161 pounds. On 11/4/14, Resident # 10's weight was recorded as 145 pounds. This represented a16 pound weight loss (a significant weight loss of 9.9%) in 30 days. Review of the record did not reveal a re-weight or new interventions placed to halt the weight loss after the November 2014 weight with the significant weight loss was recorded. Nurse progress notes, written on 11/12/14 at 9:56 AM, indicated the family had voiced concerns Resident # 10 had increased difficulty swallowing. The nurse documented swallowing difficulties were not of new onset, but the family thought the symptoms were worse. A Quarterly Minimum Data Set (MDS), dated 11/18/14, indicated Resident # 10 was severely cognitively impaired. The MDS also indicated she required limited assistance with eating. Resident # 10 ' s assessment indicated she had difficulty swallowing and had experienced significant weight loss. Her body weight was recorded as 145 pounds. A Nutritional Assessment, dated 11/18/14,	F 325	Pathologist Evaluations and Treatment ordered related to increased swallowing difficulty. Resident $45 placed on weekly weight monitoring. Nutrition supplement started 12-17-14 3x/day providing 540 calories as recommended by RD. Receiving ice cream 3x/day between meals. Able to feed self after tray setup. Regular diet with nursing providing tray setup and cutting up food as needed, has no teeth or dentures. Care Plan updated to include slow weight loss and nutrition supplements added. Prevention of Weight Loss: I. Policy: Residents with significant unplanned weight changes will be monitored and appropriate intervention initiated. B. At admission of a new resident a Licensed Nurse will obtain height and weight and record Healthcare Management System under Clinical History Profile. Certified Dietary Manager will complete Nutrition Assessment in Healthcare Management System under Nutrition Assessment form within twenty four hours of admission. Certified Dietary will visit resident and family for nutrition status. Interview for; how they eat and meat time,	

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F 325	Continued From page 44 indicated Resident # 10 had experienced a 9.94% weight loss in one month, with a 4.32% weight gain in 6 months. Under Nutritional Concerns, the Dietary Manager (DM) had documented the resident required assistance with feeding, had difficulty chewing, sore mouth, poor dentition, difficulty swallowing with thickened liquids, dysphagia and weight loss. Services documented as already in place for the resident included snacks three times a day. Documentation indicated the resident consumed 50-75% of meals and 0-100% of the snacks. Additional comments indicated the resident received a puree diet related to swallowing difficulties. On 11/18/14, the DM documented the resident had a 9.94% weight loss in one month and there was no change in her intake or physical appearance. There was no documentation that indicated the DM requested a reweight. The care plan, last reviewed on 11/20/14, identified the resident's current body weight as 145 pounds, which was listed as an acceptable body weight. The significant weight loss was not identified and interventions were not placed to halt continued weight loss. Resident # 10's December 2014 weight was recorded as 148 pounds. The RD reviewed the resident's chart on 12/10/14 and recommended to continue to monitor the weight trend and consider the addition of an oral nutritional supplement if the weight continued to trend down. There were no specific interventions identified to continue the weight monitoring.	F 325	problems chewing or swallowing, ability to feed self, history of weight loss or gain, pressure ulcers, therapeutic diet before admission, usual body weight, appetite, food allergies, food likes and dislikes, nutrition supplements, and diagnosis. Certified Dietary Manager will record all information in Healthcare Management System. Certified Dietary Manager will enter all information in Meal Tracker Dietary Software to obtain Ideal Body Weight Range, Body Mass Index, food allergies, food dislikes/likes for menu, calorie requirements, fluid requirements (based on Harris Benedict Equation). Certified Dietary Manager will complete care plan form information obtained from resident, family, nursing, and medical record. Certified Dietary Manager will document findings in Health- care Management System under Dietary Progress Note. II. Procedure: C. a.) All residents will weighed monthly. Nursing Director will designate Certified Nursing Aid for monthly weights, to be completed by the 3rd of each month. Certified Dietary Manager will provide the	

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F 325	Continued From page 45 Nursing Assistant (NA) # 1 was interviewed on 12/17/14 at 2:42 PM. The NA stated there was no one particular person assigned to obtain monthly resident weights; adding she had been assigned for December. NA # 1 stated when she had been assigned to weigh residents, she had a sheet of paper that listed their names, the previous weight and a space to place the current weight and the type of scale used (bed, wheelchair, standing). If a big difference was noted in the resident's weight, either loss or gain, she reported the weight difference both to the nurse and to the DM. Within a week, a reweight was expected. The DM was responsible for entering the weights into the computer system. The NA described Resident # 10's appetite as variable. For breakfast, the resident consumed approximately 25%, 75% at lunch with a family member feeding her. The NA stated the resident also consumed snacks that were delivered at 10:00 AM and 3:00 PM. On 12/17/14 at 3:12 PM, NA # 3 was interviewed. She stated Resident # 10's morning intake was 25-50% with her lunch intake ranging between 50-75%. The NA stated the resident received a snack at 10:00 AM and usually consumed 100%. After lunch, the RP provided a snack and made sure she ate it. NA # 3 stated at time the resident fed herself and at times she required assistance. Nurse # 1 was interviewed on 12/17/14 at 4:44 PM. Nurse # 1 stated Resident # 10 experienced intermittent problems with swallowing due to esophageal strictures, but the family had declined further dilatation. The nurse added when Resident # 10 wasn't experiencing an acute medical episode or change in condition, she ate	F 325	weight recording form to be used each month for recording weights to the Nursing Director. The form will have the Resident Room, Name, Last Weight and Date, New Weight, Stand Scale, Wheel Chair Scale Bed Scale, Reweight, and Staff initials. b.) Maintenance will check scales for accuracy. Wheelchair and bed scale on the day before monthly weights are scheduled. Maintenance will inform Nursing and Certified Dietary Manager if there is a problem with scales accuracy. Repair if needed. Maintenance will use a 2.3 pound weight to calibrate both the wheelchair/ stand scale. Maintenance will make adjustment per manufactory recommendation. Maintenance will record findings on Monthly Scale Balance/Maintenance form. This form includes the Month, Wheelchair/Stand Scale, Bed scale, Staff Name, and Comment. After form is completed Maintenance will give to Certified Dietary Manager for filing. The form will be kept in the Dietary Department. c.) Certified Nursing Aid will complete weight form, if a resident has	

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F 325	Continued From page 46 pretty well. Visually, the nurse added, it was hard to tell if the resident had weight loss since she prefers to wear layers of clothing. Family members are present during lunch and supper to help with feeding Resident # 10. On 12/17/14 at 5:05 PM, NA # 2 was interviewed. She stated that lately, Resident # 10 required more assistance with eating. At supper, the NA stated, Resident # 10 consumed 50% of her meal and 100% of her night time snack. The Assistance Director of Nursing (ADON) was interviewed on 12/17/14 at 5:34 PM. She stated the Facility had a risk committee where weight loss was discussed. The ADON stated interventions for weight loss were individualized. The ADON stated she thought Resident # 10 had refused supplements and added she was picky with her diet. She acknowledged significant weight loss should be addressed on the care plan. The ADON explained if the DM thought a weight was inaccurate, she would be responsible for requesting a reweight before any weight was entered into the electronic medical record. Additionally, if a resident had lost or gained 5 pounds from the previous week, a reweight was required within a week. The ADON stated NA's were responsible for obtaining monthly weights. An interview was held on 12/18/14 at 9:50 AM with the Director of Nursing (DON). The DON stated issues affecting residents were encompassed in the "at risk" meetings held weekly. Attendees in addition to the DON included the DM, the ADON, and the DM. Typically, the DM reviewed residents with a 5-10% weight loss. The DON stated some residents were on planned weight loss programs,	F 325	had a five(5) pound weight loss or gain the resident will be re-weighed the next day. Certified Dietary Manager will follow through with list of residents for re-weight. The re-weigh will be added the next day to Monthly Weight Form. d.) Weight will be given to Certified Dietary Manager whom, will enter into Meal Tracker Dietary Software for weight variance also, enter in Clinical History Profile and Vital Signs in Healthcare Management System. Weight will be entered in each resident profile in Meal Tracker Dietary Software by Certified Dietary Manager. A copy of six month, three month and one month weight variance record calculated by Meal Tracker Dietary Software will be placed on weight clip board at Long Term Care Nursing Station. A copy of monthly weight variance from Meal Tracker Dietary Software will be given to MDS (Minimum Data Set) Coordinator and Nursing Director. e.) Residents with a 5% weight loss, 5% weight gain, 10% weight loss and 10% weight gain will be considered at nutritional risk. Nutrition Risk are residents with low	

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F 325	Continued From page 47 but Resident # 10 was not included in that number. The DON added concerns been expressed about Resident # 10 ' s weight loss in the "at risk" meetings. She was not able to verbalize any interventions discussed related to Resident # 10's weight loss. The DON added she expected significant weight loss to be care planned by the DM. An interview was held with the DM on 12/18/14 at 10:41 AM. The DM stated there had been no interventions added for Resident # 10's significant weight loss since the resident's intake had not changed and she had not been sick. The DM stated at one point Resident # 10 had received supplements. She added they were discontinued some time back because of weight gain. The DM stated she was responsible for care plans for nutrition. Typically significant weight loss was care planned. She stated she had not care-planned Resident # 10 for significant weight loss because she thought it was an inaccurate weight. The DM added if a resident lost weight she would assess the resident for pain, food preferences, pain decline in the ability to eat and make observations of the resident during meals. She added she preferred adding nourishments such as sandwiches, ice cream or milk shakes between meals prior to initiating supplements. The DM stated she also had concerns with accuracy of the scale; adding she thinks the loss recorded on Resident # 10's chart were not true weights, but thought the scale may not have been balanced correctly. She added this could be because the same person or the same chair or type (weight obtained using a standing scale, bed scale or wheelchair scale) of weight may not be consistent. The DM added the bed scale weights seemed more inaccurate than the others. She	F 325	po-intake, weight loss, inability to feed self, chewing or swallowing onset, mental status change, behavior problems, refusing to eat, decline in health (nausea, vomiting, diarrhea). f.) Resident with significant weight changes will be placed on weekly weights using Weekly Weight Tracking Record form. The form will have resident's room, name, week of (one column for four days) weight, initial of Certified Nursing Aid or Licensure Nurse who weighed the resident, and continue weekly weight Yes? No?. Resident will remain one weekly weights until weight has been stable for four weeks. g.) Certified Dietary Manager will monitor and follow through for re-weight and weekly weights. If not completed when requested Certified Dietary Manager will notify Chief Executive Officer of problem. h.) Certified Dietary Manager will notify Register Dietitian Consultant of residents considered at nutritional risk related to significant weight loss of five percent (5%) in one month and ten	

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F 325	Continued From page 48 stated she had brought up the fact the weights are inaccurate at the "at risk" meetings over the last few months, but was sure there was no documentation that inaccuracy of weights had been discussed. The DM stated she had no idea if the scales had been calibrated. After getting no reply from the other members of the "at risk " meeting, the DM stated she had done nothing more about her concerns. The DM stated reweights were done for any resident experiencing a 5 pound loss or gain from the previous month. She expected the reweights to be completed the next day if possible. The DM added there had not been any reweights in a long time. She stated reweights had been needed, but reweights have just not been done. The DM stated she had reported the lack of reweights to the DON. An observation was made of the resident eating her lunch on 12/18/14 at 12:30 PM. The resident's meal was pureed and had been served on a divided plate. The family member was feeding the resident. It was noted, she was eating slowly. There were no indications of problems with swallowing. An interview was held with the resident's family member on 12/18/14 at 12:41 PM. He stated he had concerns with the resident's eating. He added as long as Resident # 10 ate slowly she had no problems chewing and swallowing. The family member added he came at lunch to feed her to make sure she got the time to eat that she needed. 2. Resident #45 was admitted to the facility on 5/10/2014, with diagnosis to include hemiplegia	F 325	percent (10%) in six months. A weight alert form with information of current weight, previous month weight, six month weight, height, ideal body range, body mass index, diet, po-intake, nutrition supplement, feeding problems, chewing or swallowing problems will be completed by Certified Dietary Manager. Certified Dietary Manager will provide a copy to Register Dietitian Consultant, Medical Doctor, and Nursing Director and follow all recommendations. License Nurse will notify family of weight changes and any recommendations. Weight Alert Form after completion will be given to Certified Dietary Manager who will review all recommendations for completion. Certified Dietary Manager will give form to Medical Record for scanning into Electronic Medical Record. i.) CDM (Certified Dietary Manager) will complete Nutrition Weight Loss/Gain Assessment for each week for residents on weekly weights which includes: 1.) Current weight for four weeks 2.) Significant weight changes 3.) Oral health status	

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F 325	Continued From page 49 and dementia. Her admission weight was 179 pounds (lbs.). A review of the physician orders revealed that Resident #45 was started on a protein nutritional supplement on admission of 5/10/2014. The vital sign record indicated the Resident's weight in June 2014 was 179 lbs. Her weight in July was recorded as 171 lbs., in August 174 lbs. and in September, 172 lbs. Resident #45's Care Plan dated 8/22/2014 listed a risk for choking and problem with pocketing food, with history of significant weight loss related to low intake and receiving nutrition supplement. Acceptable body weight 125 lbs. The intervention included the protein nutrition supplement 3 times a day, which the resident was receiving since admission. A Dietary Manager (DM) progress note dated 8/22/2014 stated the resident was on a mechanical soft diet related to history of pocketing food and chewing. Resident stated she would eat better if her food was not messed up, referring to mechanical-soft. She can chew and swallow without difficulty. Nursing staff may cut up food. If intake and weight remains stable will consider stopping supplement. Plan for diet of regular with nursing staff cutting up food; monitor for difficulty chewing related to history of pocketing food and no natural teeth; monitor weight monthly for significant changes; and nutrition supplement for weight maintenance. Physician order dated 8/22/2014 stated Diet: regular with thin liquids. Physician order dated 9/8/2014 stated to discontinue the protein nutritional supplement. A review of the resident's electronic MAR revealed that she received a nutritional supplement three times per day from 5/10/2014 until 9/9/2014.	F 325	(chewing/swallowing) 4.) Current diet and consistency 5.) Percentage or po-intake as observed or documented by Certified Nursing Aid 6.) Nourishment/Nutrition Supplement accepted 7.) Dental issues impacting ability to eat/drink 8.) Able to eat/drink by self 9.) Adaptive devices for eating/drinking 10.) Oral health status (swallowing) 11.) GI issues (nausea, vomiting, or diarrhea) 12.) Medication related to dietary needs 13.) Skin impairment 14.) Labs reviewed 15.) Usual dining experience 16.) Food preference changes 17.) Care plan intervention, revise and implemented j.) Certified Nursing Aid will document in Healthcare Management System residents po- intake and nourishments under Certified Nursing Aid Care Sheet. Each Certified Nursing Aid will record po-intake and nourishment of resident whom they have been assigned. The percentage range from refused (0%) to complete meal at one hundred percent (100%). Nourishment	

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F 325	Continued From page 50 The vital sign record indicated the Resident's October weight as 166 lbs., November was recorded as 155 lbs. and December was 156 lbs. A Registered Dietician (RD) progress note dated 10/15/2014 stated recommend continuing nutritional supplements for now. No documentation of nutritional supplements recorded after 9/9/2014, when the supplement was discontinued. The resident 's care plan was updated 11/2/2014 and stated "155lbs." The weight loss was not identified and interventions were not placed to halt continued weight loss. A Quarterly Minimum Data Set (MDS), dated 11/23/2014, documented Resident #45's cognitive ability as moderately impaired. The MDS indicated she was independent with eating, after tray set up, did not hold food in her mouth, and did have a significant weight loss. A DM progress note dated 11/23/2014 stated "has had 6.63% weight loss which is questionable, no change in eating habits or change in appearance from previous month. Has a 13.41% weight loss in six months." Will continue care plan and add weight loss with ice cream added between meals. A RD note dated 12/10/2014 stated due to weight loss, recommend protein nutritional supplement 3 times per day. This recommendation was not acted upon, because there were no orders for protein supplement in the resident's record. On 12/17/2014 at 12:20 PM, Resident #45 was observed to be eating lunch in the dining room. She ate all of her chicken and 2 bites of pie. She did not eat her potatoes, vegetables, or bread. Resident fed herself during the observation. An interview was conducted with the Dietary Manager (DM) on 12/17/2014 at 3:28 PM. The DM stated that Resident #45 doesn't look like she has lost weight, so the DM questioned the validity	F 325	offered at ten o'clock, three o'clock and approximately eight o'clock will be recorded by Certified Nursing Aid for each resident they are assigned as refused or accepted. License Nurse will document in Healthcare Management System nutrition supplement under medication administered. License Nurse will record in comment section of medical administered the percentage of nutrition supplement accepted, from refused (0%) to one hundred percent (100%. III. Certified Dietary Manager will present at the At Risk Meeting residents with significant weight changes or trend on monthly or weekly weights. 1.) Certified Dietary Manager will follow up for orders if supplements have been added or other changes to prevent further weight loss to include total feeding. 2.) Certified Dietary Manager will follow up on recommendations from Register Dietitian and Medical Doctor for completion. IV. Certified Dietary Manager will present findings and trends at Quality Assurance Meeting	

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F 325	Continued From page 51 of the scale and if the resident really lost weight. The DM stated Resident #45's protein supplement was stopped in September because her weight was stable, and the previous weight loss had been attributed to the mechanical soft diet that the resident did not like. The DM stated that once the resident was back on a regular diet she had been eating well. The DM stated that the resident's intake for 12/17/2014 at the lunch meal was documented by the nursing assistant as 50 to 75%, and she knew that wasn't correct, because the resident always ate all that was on her tray. The DM had not seen the dietician's recommendation to restart the protein supplement on 12/10/2014, so the DM had not initiated the recommendation. The DM stated the nursing assistants weigh the residents on the first of the month, but it is not consistent with the same nursing assistant, or the same scale. The DM stated that weights are discussed in the risk meeting every week, and she has brought this residents monthly weights to the meetings. On 12/18/2014 at 2:21 PM, an interview was conducted with Nursing Assistant #6 (NA #6). NA #6 stated she used to do all the weights for the facility, but about 3 months ago, the facility started assigning other nursing assistants to do the weights. NA #6 stated that she would weigh the pad on the lift first, then slide the pad under the resident and use the lift to weight the resident, so she would have the true weight. If the resident had a weight gain or loss, she would re-weigh the resident right then, and she would report the gain or loss to the MDS nurse, who would notify the DM. NA #6 stated that if a resident lost weight, she would do a weight on them the following week, but did not know where that information would be documented. On 12/18/2014 at 3:33 PM, an interview was	F 325	with follow up recommendation completed, Care Plans update and revised, Supplements, Assessments, Weights and re-weight. V. Certified Dietary Manager will present to Inter Disciplinary Team (IDT) findings, trends, follow up, care plans revised, supplements and assessments. Discuss with family nutrition status and weight changes. In-Services: Nutrition and Weight Loss/Gain. Mandatory for all Nursing staff. Completed on January 8, 2015 by Roxanne Godley, RD. Register Dietitian present in-service to License Nurse and Certified Nursing Aid; Factor That Can Contribute To Weight Loss, Ways To Help Prevent Weight Loss, and Proper Weighting Techniques. Some factors that contribute to weight loss: Decreased sense of taste and smell. Decreased stomach size with early sense of fullness. Decreased in hungry and appetite. Decreased in mental awareness. Reduced desire or inability to eat appropriate food. Chronic disease. Medication use. Infection and other illness.	

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F 325	Continued From page 52 conducted with the Director of Nursing (DON), who stated that resident ' s weights were discussed in the "at risk" meeting held weekly. The weight committee, which included the DON and the DM, discussed the weights, but the DON depended on the DM to make the suggestions. The DON stated that weights on residents were done on a monthly basis. If weights were needed weekly it would be only short term. The DON stated that there was no problem with the weight scale, as it was calibrated before the start of the weights, every month by the nursing assistants.	F 325	Ways to prevent weight loss: Weigh resident within 24 hours of admission. Weigh new tube feeding weekly until stable weight trend is documented. Ensure proper documentation of po-intake is recorded at each meal and snack. Re-weigh resident within twenty-four (24) hours of noted weight loss. Document and report any food preferences or dislikes that are communicated by resident or observed by staff to dietary staff. Notify Certified Dietary Manager or License Nurse of any changes in residents eating habits or behaviors that can contribute to weight loss. Proper Weight Techniques: Explain procedure to resident. Weigh resident at approximately the same time and with approximately the same type of clothes to have comparison be meaningful. Bring resident by way of independent ambulation or wheelchair to weighing area. Balance scales-do this before resident is placed on scale. A Balance Scale Bar should be in the middle. Have residents stand on center of scale not holding onto scale. Move bar until scale is balanced and record weight. For wheelchair standing weight, make sure the ramps are not down and resident not holding and steady. Record weight. Wheelchair weighing make sure the ramp is down, stabilize the chair as much as possible. Remove resident from wheelchair and weigh chair separately so weight can be subtracted from total weight in order to obtain correct	

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F 325	Continued From page 53	F 325	weight. Weigh wheelchair each time a weight is obtained. Bed-Scale/Sling place under resident. Place lifting apparatus on lifter, lift resident clear of bed. Read weight and record. Lower resident on bed and remove lift sling.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the	F 329	A. It is the policy of this facility that each	1/16/15

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F 329	Continued From page 54 facility failed to give medication as the physician ordered for 1 (Resident #19) of 5 residents reviewed for unnecessary medications that caused the resident to receive 18 days of Seroquel at the wrong dosage. The findings include: Resident #19 was re-admitted to the facility on 10/18/2014, with diagnosis to include cyclothymic disease which is a mood disorder, depression, anxiety, and late effects of a stroke. Her comprehensive minimum data set (MDS) assessment dated 9/29/2014 revealed severe cognitive impairment. An observation of Resident #19 was conducted on 12/17/2014. The Resident was seated in her wheelchair in the dining room for a music activity. Her hair was combed, and her clothes were clean. She was alert, calm, and looked around at the other residents present for the activity. A physician order dated 8/8/2014, was for Seroquel, an antipsychotic medication used to treat depression, 25 milligrams (mg) in the morning, and Seroquel 50 mg in the evening, daily. A consultant Pharmacist's Resident Review sheet was written on 11/24/2014, and recommended Gradual Dose Reduction (GDR) of Seroquel from 25 mg in the morning and 50mg in the evening, to 25mg twice per day. The Physician agreed with the GDR, and signed the sheet on 11/28/2014. A medication order was written on 12/1/2014 that stated to "change Seroquel to 25mg" twice per day, and was signed by the Director of Nursing (DON). The order was not carried out and transcribed to the resident's MAR. A review of Residents #19's electronic Medication Administration Record (MAR), revealed the resident received Seroquel 25 milligrams (mg) in the morning, and Seroquel 50 mg in the evening	F 329	resident's drug regimen will be free from unnecessary medications. For resident #19 this will be achieved by review of all orders by the consultant pharmacist and by the Director of Nursing or by the Assistant Director of Nursing to ensure that all orders are noted, entered into the Electronic Medication Administration Recorded (EMAR) and ordered from the pharmacy. (Director of Nursing, Consultant Pharmacy) Resident #19's attending physician was notified that resident had received the wrong dose of Seroquel for 18 days. A clarification order was received on 12/18/14 to discontinue Seroquel 50mg at hs and to give Seroquel 25mg po twice a day. The order was received, noted, entered into the resident's EMAR, called into the pharmacy and initiated. (12/18/14) B. Corrective action to ensure practice does not affect resident #19 or any other residents the following has been done. 1. 100% of all resident's orders have been reviewed, including all written and/or verbal orders and the monthly orders for January have been reviewed and approved. All newly written or verbal orders are being reviewed on a daily basis. (DON,Consultant Pharmacist)12/29/14 2. A new policy was written entitled "Prescriber Medication Orders" outling for the nursing staff all elements of the medication order, such as how to note, receive, call into pharmacy and initiating the order. An inservice has been presented to the nursing staff and a copy	

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F 329	Continued From page 55 from 12/1/2014 until 12/18/2014. An interview with the DON on 12/18/2014 at 2:36 PM, stated she wrote the order on 12/1/2014. She then flagged the order for the floor nurse to implement and update the electronic MAR. The DON stated it was her expectation that the floor nurse would have carried out the order. The resident's MAR was updated on 12/18/2014 to the decreased dosage of Seroquel.	F 329	of the policy has been placed in the pharmacy manual at the long term care nurse's desk with a copy placed in the nurses "Memos and Reminders" notebook which is kept at the nurses desk and checked daily by staff. (12/31/14. 1/12/15,1/13/15) (Director of Nursing) 3. After an order is written or received, it will be noted, entered into the Electronic Medication Administration Record, and called into the pharmacy. 4.For any discrepancy in an order or if an order was overtly omitted or entered incorrectly, the resident's physician will be notified. All orders for other residents have been reviewed by the DON and the consultant Pharmacist. 1/1/15 C. Measures which have been put into place to ensure compliance and to prevent practice from occurring. 1. The nurse who receives and notes the order will enter the order either into EMAR or onto the Treatment Administration Record (TAR) as applicable. 2. All MD orders are triplicate; the white copy is retained and kept in the resident's medical record chart once signed by the MD,the pink copy will be placed in the pharmacy box at the nurse's station for pick up and review by the pharmacist. 3. After the order(s) have been entered into EMAR or TAR, the consultant pharmacist will review the medication order entered, checking it against the written physician order. If the order has been completed accurately, the pharmacist will sign the order as verified.	

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F 329	Continued From page 56	F 329	3. The pink copy of the order will be returned to the Director of nursing (DON) after pharmacist has reviewed and verified. The DON will double check EMAR and/or TAR for accuracy. 4. The consultant pharmacist will notify the DON with any discrepancies or irregularities. The DON will address with individual nurse(s) as needed. (1/12/15) D. The Director of Nursing (DON)will monitor compliance with the MD orders and will report to Risk Management each week any problems encountered and with corrective actions as needed. The DON will also present a detailed report each month at the Quality Assurance Committe Meeting with a focus on irregularities, missed orders. Compliance will be monitored through chart audit by the DON and by the consultant pharmacist during his monthly chart reviews. Orders will be reviewed and verified by the consultant pharmacist through the resident's electronic medical record order entry. The consultant pharmacist will present a summary of any pharmacy issues pertaining to unnecessary medications every quarter at the Quality Assurance Committee. The consultant pharmacist will review and verify 100% of the physician orders, the DON will review 100% of the orders to "double check" accuracy in electronic medication administration record and to ensure that orders have also been written on the treatment administration record (TAR) as needed. (1/16/15)	

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F 332	Continued From page 57	F 332		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility medication error rate was 7.69% due to 2 errors (Residents #4 and #28) out of 26 opportunities for error. The findings included: 1. Resident #4 was readmitted to the facility on 11/7/14. Diagnoses included hemiplegia, status post gastrostomy, osteoporosis, epilepsy and constipation. On 12/17/14 at 9:10 am, Nurse #3 was observed to crush chewable baby aspirin 81 milligrams (mg) and four tablets of Vitamin D 1000 mg. The nurse mixed the crushed tablets together in a cup and added water to dissolve them. The nurse also measured out the following liquid medications and poured them into one cup: multi-vitamin 5 milliliters (ml), Keppra (a seizure medication) (100mg/ml) 7.5 ml, valporic acid (a seizure medication) (250mg/5 ml) 10 ml, calcium carbonate (used in treatment of osteoporosis) 1250mg (5 ml) and sorbitol 70% solution (a laxative) 15 ml. After checking tube placement, ensuring patency and flushing with water, Nurse #3 administered the liquid medications followed by a 15 ml water flush, then the dissolved medications that had been crushed followed by a 35 ml water flush. Review of physician orders for December 2014 revealed no order to administer the medications	F 332	In order to maintain a medication error rate of <5% the policy for enteral tube medication was revised to say "for administering medications via tube feeding, the standard of practice will be to administer each medication separately" (12/22/14) A. Medication observations have been observed for residents #4 and #28 to ensure that nursing staff is administering each medication seperately. Compliance has been met by 4 of 4 nurses observed by ADON. (12/22/14 and 12/23/14) B.To ensure compliance of the revised policy and to ensure that the residents #4 and #28and other residents will not be affected by the practice, all nurses have been in-serviced on the policy change of administering enteral medications seperately. (DON) (12/22/14 and 1/12/15) A copy has been placed in the memo book at the nurses desk as well as in the pharmacy policy and procedure manual. 12/22/14 C.To further ensure compliance for	1/16/15

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F 332	Continued From page 58 together or to limit fluids. During an interview on 12/17/14 at 2:58 PM, Nurse #3 stated the facility policy allowed medications to be mixed when being via gastric tube although in school she had been taught to give the medications separately. The Director of Nursing (DON) was interviewed on 12/18/14 at 8:30 AM. She stated when giving medications by tube the nurses were expected to follow the facility policy. She added the policy had been revised in 2013 with recommendations from the pharmacist and the Medical Director. The DON stated it was her understanding medications could be crushed and given together as long as there were no adverse reactions to the combination of medications. She added the Administrator received updates from the Centers for Medicare and Medicaid and shared any nursing issues with her. The DON stated the pharmacist was in the facility frequently. During his monthly review, he does random medication pass observations. The DON added the consultant pharmacist had observed medications given via feeding tubes and had not directed staff to give each medication separately. On 12/19/14 at 8:44 AM, the DON stated she had spoken to the consultant pharmacist. He told her from a pharmaceutical standpoint, there was no reason the medications could not be crushed and given together. The telephone interview with the consultant pharmacist was held on 12/19/14 at 2:40 PM. He stated during medication administration observations he had not directed staff to give medications by tube separately. 2. On 12/17/14 at 10:25 AM, Nurse # 1 was	F 332	residents #4 and #28 and for all residents with the potential to be affected, the DON or Assistant Director of Nursing will do medication observations on each shift 4 times a month on an on-going basis until compliance is met.Medication observations will continue by DON or Assistant Director of nursing at least quarterly when compliance has been met. The consultant pharmacy will watch medication pass at least quarterly and more often as needed for a new employees. 1/15/15 and 1/16/15 D.Any irregularities will be corrected during the medication pass as necessary. Findings of the medication observation will be reported by the DON at the monthly QA meeting with the corrective action measures as needed. The consultant pharmacist will send a summary of his findings and corrective action, suggestions, or recommendations to the DON to be presented at the QA meetings as well. (1/16/14)	

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F 332	Continued From page 59	F 332		

observed preparing medication for Resident # 28. The nurse crushed Famotidine (a medication used for gastric reflux) 20 milligrams (mg), Aspirin 81 mg and Lopressor (a medication used to control blood pressure) 25 mg. After crushing the medications, Nurse # 1 mixed the crushed medications into one cup using water to dissolve the medications.

After checking placement of Resident # 28's feeding tube, the nurse instilled water into the tube, poured the cup of medications into the tube and then flushed the tubing with more water.

Review of the most current physician's orders for December 2014, revealed no order to administer all the medications together or to limit fluids.

An interview was held with Nurse # 1 on 12/17/14 at 4:47 PM. She stated it was facility policy to give all crushed medications at once through the tube and then to give liquid medications. She added she had worked at the facility for 5 years and no one had instructed her she could not crush all the medications together and give them through a feeding tube together.

The Director of Nursing (DON) was interviewed on 12/18/14 at 8:30 AM. She stated when giving medications by tube the nurses were expected to follow the facility policy. She added the policy had been revised in 2013 with recommendations from the pharmacist and the Medical Director. The DON stated it was her understanding medications could be crushed and given together as long as there were no adverse reactions to the combination of medications. She added the Administrator received updates from the Centers for Medicare and Medicaid and shared any

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F 332	Continued From page 60 nursing issues with her. The DON stated the pharmacist was in the facility frequently. During his monthly review, he did random medication pass observations with the nurses. The DON added the consultant pharmacist had observed medications given via feeding tubes and had not directed staff to give each medication separately. On 12/19/14 at 8:44 AM, the DON stated she had spoken to the consultant pharmacist. He told her from a pharmaceutical standpoint, there was no reason the medications could not be crushed and given together. The telephone interview with the consultant pharmacist was held on 12/19/14 at 2:40 PM. He stated during medication administration observations he had not directed staff to give medications by tube separately.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a barrier between ready-to-eat foods and bare hands for 1 of 5	F 371	A. For resident #50 the requirement has been met as evidenced by observations of staff on a daily basis in the dining room or	1/16/15

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F 371	Continued From page 61 residents (resident #50) observed being fed by a staff member. The findings included: During an observation of Resident #50 on 12/17/14 at 3:15 PM Nursing Assistant #7 was seen feeding him a snack of a honey bun and milk. The honey bun was in bite size pieces and setting on the wrapper on top of the over bed table. Nursing Assistant #7 picked up a piece of the honey bun with her bare fingers and placed it in Resident #50 ' s mouth. She then picked up a carton of milk and assisted the resident with a swallow of the milk. Next, she picked up another piece of honey bun and fed it to Resident #50. She was not wearing gloves or using any utensils while feeding the resident his snack. During an interview with Nursing Assistant #7 on 12/17/14 at 5:42 PM she stated she had fed Resident #50 his snack that afternoon. She stated she broke the honey bun into bite size pieces. She stated she used her bare hands to feed the resident. She added that she knew it was wrong to use her bare hands to feed the resident. She also stated she should have worn gloves but she did not take time to put on gloves. An interview with the Director of Nursing (DON) on 12/19/14 at 10:50 AM revealed she expected the staff to use gloves or utensils to handle ready-to-eat foods.	F 371	in resident's room feeding "finger foods". CNA's were wearing gloves or using a fork when giving finger foods to the resident. Gloves are accessible in the resident's room and in the dining room for the convenience and use of the staff. (Director of Nursing and Assistant Director of Nursing 12/22/14) The CNA who was originally observed not using a barrier between ready to eat foods has been instructed by the Assistant Director of Nursing that gloves must be worn when feeding "finger type foods" to residents.(12/18/14) B. To ensure that no other residents will be affected by this practice an in-service was presented on safe food handling practices for all dietary and nursing staff. In-serviced focused on hand washing, wearing gloves, and basic safety and sanitary issues when handling foods. (Registered Dietician 1/8/14) (Assistant Director of Nursing and Staff Development Coordinator 1/11/15 through 1/14/15) C. Measures which have been initiated to ensure that practice of not using a barrier between ready to eat foods will not occur: 1. All new dietary employees and nursing employees will be in-serviced when hired. 2. An in-service will be conducted annually on Safe Food Handling Practices. 3. On-going observations daily in the dining room and also observations of resident #50 and other residents who are fed in their room. (Assistant Director of Nursing, Staff Development Coordination,	

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F 371	Continued From page 62	F 371	Floor Charge Nurses (LPNs and RNs) and Certified Dietary Manager) D. Safe Food Handling compliance will be monitor on an on-going basis. Results of mealtime observations will be compiled by the Certified Dietary Manager and given to the Director of Nursing. Findings of the observations will be presented to Quality Assurance Committee monthly for a period of six (6) months and then quarterly thereafter with corrective action(s) taken as needed and follow up with specific employees if needed. Compliance threshold: 100% of staff wearing gloves when handling foods serviced to the residents. (Certified Dietary Manager, Director of Nursing)	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425		1/16/15

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F 425	Continued From page 63 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and consultant pharmacist interview, the consultant pharmacist failed to advise the facility when administering medications via gastric tube, the standard of practice was to administer them individually for 2 of 2 residents (Residents #4 and #28) with gastric tubes observed during med pass. The findings included: On 12/17/14 at 9:10 AM, Nurse #3 was observed mixing medications together prior to administering them via gastric tube (g-tube) to Resident #4. On 12/17/14 at 10:25 AM, Nurse #1 was observed mixing medications together prior to administering them via g-tube to Resident #28. Nurse #3 was interviewed on 12/17/14 at 2:58 PM. She indicated facility policy allowed for medications to be mixed together prior to administering them via g-tube. The nurse added that she had been taught in school to administer the medications separately. Nurse #1 was interviewed on 12/17/14 at 4:47 PM. She indicated it was facility policy to give all crushed medications at once through the tube and then give the liquid medications. During an interview on 12/18/14 at 8:30 AM, the Director of Nursing (DON) stated the facility policy for administering medications via g-tube was last revised in 2013 with recommendations from the pharmacist and Medical Director. The DON indicated the policy allowed for mixing medications prior to administration and that she	F 425	A. For residents # 4 and #28 the requirement has been met as evidenced through medication observations, correct administration of medications being given via gastric tube. For resident #4,8 medications were placed in pill cup and each medication was given seperately. For resident #28,16 medications were placed in pill cup and each medication was given seperately by the nurse(s) administering the medication Medications were given correctly by 4 of 4 nurses observed. (Assistant Director of Nursing 12/22/14 and 12/23/14) B. To ensure that medications administered via gastric tube are give seperately for all other residents having the potential to be affected, the policy for enteral medication was revised by Consultant Pharmacist to say "for administering medications via tube feeding, the standard of practice will be to administer each medication seperately". C. In addition when facility Administrator receives updates or changes to the State Operations Manual (SOM) he will forward copies of those changes to the Consultant Pharmacist as they are received. The consultant pharmacist will review the publication from the American Society of Consultant Pharmacist who also	

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F 425	Continued From page 64 expected the nurses to follow the policy. A telephone interview was conducted with the pharmacist on 12/19/14 at 2:37 PM. The pharmacist stated that he participated in writing the policy on administering medications via g-tube. He indicated he advised the facility to administer liquid medications separately from crushed medications. The pharmacist said he was aware the standard of practice was to give each medication separately and could not explain why he did not advise the facility to write the policy accordingly.	F 425	publishes changes to the SOM. Consultant Pharmacist will keep the facility Administrator and the Director of Nursing informed on any changes that need to be made and assist with initiating those changes. Consultant pharmacist will assist the Director of nursing in reviewing, revising and writing new policies as changes warrant. C.The revised policy on enteral feeding was in-servied to the nursing staff by the Director of Nursing and the Assistant Director of Nursing. The Consultant pharmacist also addressed with each nurse during medication observation on a 1 to 1 basis. (12/22/14 and 1/12/15) A copy of the policy was placed in the Pharmacy Policy and Procedure Manual at the long term care nurse's desk. (Director of Nursing 12/22/14) A copy of the policy on enteral feeding was also placed in the "Reminders and Memo" notebook which is kept at the nursing desk in long term care and reviewed by nurses on each shift daily. Medication observations will be done 4 times a month on an on-going basis. The consultant pharmacist will watch medication pass at least quarterly and as needed for any new employees D.The facility Administrator will monitor the Consultant Pharmacist regarding CMS recommened changes to any subject involving pharmaceutical care. The Administrator will ensure that both the facility and the consultant pharmacist	

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	345431	A. BUILDING _____ B. WING _____	12/19/2014

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F 425	Continued From page 65	F 425	have acces to the current State Operations Manual (SOM). The Administrator will also review for changes in the SOM and CMS Guidance to Surveyors through professional organizations and publications as well as reviewing CMS website at least quarterly. In addition, any changes will be monitored by requiring the Consultant Pharmacist to provide a report regarding how any changes affect facility and/or its residents and what steps will be taken to ensure compliance. A report will also be submitted in writing to the Quality Assurance Committee regarding the medication observation passes with findings, trends and corrective action as indicated. This report will be submitted monthly for 3 months and quarterly thereafter. (Director of Nursing, Assistant Director of Nursing, Consultant Pharmacist) 12/29/14	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520		1/16/15

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F 520	Continued From page 66 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to have a Quality Assessment and Assurance program that developed and implemented a plan of action. The findings include: On 12/19/14 at 9:43 AM, an interview was conducted with the Administrator, who stated that he was the chairman for the Quality Assessment and Assurance committee (QAA). The committee met once per month with various members of the team, so that each department was represented quarterly. The Administrator could not describe the process for a QAA problem, except on an individual basis. The Administrator stated that weight loss, falls, and accident concerns were discussed in a weekly " at-risk " meetings and data from those meetings was brought to the QAA meetings by the Director of Nursing. No documentation could be provided by the Administrator to demonstrate the collected data was developed and implemented into a plan of action to address the quality deficiencies of weight loss, falls or accidents.	F 520	A.The facility will maintain a QA committee consisting of the DON, physician and 3 members of the staff. The committee will meet monthly to access what quality activities are necessary and monitor corrective action of the identified issues. Thresholds of success will be set and a plan of action will be implemented as necessary for quality problems. The problems will be monitored monthly for three months and if the threshold is met the problem will be reviewed again in six months or sooner if needed. If the threshold is not met or if substantial improvement has not been made in three months a new plan of action will be implemented. All problems identified during the survey of December 19, 2014 will be monitored and reported for three months and reviewed again in six months or sooner if needed. Quality concerns are identified by issues which have been addressed at the Risk Management Meeting, use of the Quality	

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F 520	Continued From page 67 Quality concerns of weight loss and falls were assessed on a resident to resident basis. The Administrator could not describe the process, but stated he believed his staff knew what to do for resident problems. He stated that any nurse can put a plan in place. The Administrator stated that if an intervention had not worked for a fall, for example, then the nurse would plan for additional interventions. No documentation or description could be given for how the evaluations for the interventions were conducted, and what process would be used to plan additional interventions. There was no documentation for QAA implementation and evaluation. The Administrator described a QAA plan that was completed in 2014 that the Dietary Manager had conducted on refrigerator temperatures. He did not have any process that he could show a plan of action for the temperatures. An interview was conducted with the Dietary Manager on 12/19/2014 at 14:15 PM. The DM stated she was retrieving information from the computer for QAA. The information was dated from 2011. She stated she had not done any charts for data for 2014.	F 520	Indicator reports as generated by information from the Minimum Data Set, from information generated from data entered and analyzed by the Abaqis Quality Management System (a system which replicates the Quality Indicator Survey methodology)and annual surveys/complaint investigations.	